

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-030915
STATE FILE NUMBER
7830

FILED AUG 28 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7830

5. 300
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis, Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hosp. 0 Length of stay in lb 0		d. STREET ADDRESS 2811 S. Kingshighway (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last REV. LAWRENCE A. ROST			4. DATE OF DEATH Month Day Year Aug. 10, 1958		
--	--	--	--	--	--

5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 22, 1904	9. AGE (In years last birthday) 54 0	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
---------------	------------------------	--	--------------------------------	--------------------------------------	-----------------------------	-----------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pastor	10b. KIND OF BUSINESS OR INDUSTRY Holy Innocents Ch.	11. BIRTHPLACE (City and state or country) Mo. Jefferson City,	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	--	--	-------------------------------------

13a. FATHER'S NAME Frank Rost	13b. MOTHER'S MAIDEN NAME Margaret Hentges	14. NAME OF HUSBAND OR WIFE --
-------------------------------	--	--------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Rev. A. J. Marschner, Adm. 2401 Carr St. Address
--	------------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>General Cachexia</i> DUE TO (b) <i>Lymphatic Sarcoma</i> DUE TO (c) <i>2001</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i> <i>Chronic</i>
---	--	--

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
---	--	--

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY	Hour	Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
--	--	---

21. I attended the deceased from Death occurred at <i>11:55 P.</i> on <i>Aug 10, 1958</i> and last saw him alive on <i>Aug 10, 1958</i> on the date stated above; and to the best of my knowledge, from the causes stated.	
--	--

22a. SIGNATURE (Degree or title) <i>Joseph J. Roster M.D.</i>	22b. ADDRESS <i>4768 St. Delmar</i>	22c. DATE SIGNED <i>8/10/58</i>
---	-------------------------------------	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-14-58	23c. NAME OF CEMETERY OR CREMATORY Calvary	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
--	-------------------	--	--

24. FUNERAL DIRECTOR ADDRESS Kriegshauser-4228 S. Kingshighway	25. DATE RECD. BY LOCAL REG. AUG 1 2 '58	26. REGISTRAR'S SIGNATURE <i>J. Earl Smith M.D.</i>
--	--	---

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

APR 28 1938

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *William B White*

Licensed Embalmer No. *4296*

P. O. Address *7228 Lexington High*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.