

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-042566

STATE FILE NUMBER

FILED DEC 1 1958

Registration District No. 317

Primary Registration District No. 541

Registrar's No. 2971

300
1-57

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. CITY St. Louis	
b. CITY OR TOWN Clayton	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Webster Groves	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. L. Co. Hosp.		Length of stay in lb D.O.A.	d. STREET ADDRESS (If outside, give location) 101 N. Elm Ave.

3. NAME OF DECEASED (Type or print) ROSEMARIE; LUISE ROGASCH			4. DATE OF DEATH 11-15-1958	
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5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-7-1958	9. AGE (In years last birthday) 3 IF UNDER 1 YEAR 8 IF UNDER 24 HRS. 8 Months Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and state or country) St. Louis Mo.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Alex Rogasch	13b. MOTHER'S MAIDEN NAME Meta Marie Bleiber	14. NAME OF HUSBAND OR WIFE -----
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -----	16. SOCIAL SECURITY NO. -----	17. INFORMANT Alex Rogasch Address 101 N. Elm Ave.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial pneumonia		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 525X		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	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
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred on _____ on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE Herbert R. Domke MD	22b. ADDRESS 801 S. Brentwood Clayton, Mo.	22c. DATE SIGNED 11/19/58
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-17-1958	23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	23d. LOCATION (City, town, or county) Kirkwood Mo.
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24. FUNERAL DIRECTOR Parker-Aldrich ADDRESS Webster Groves Mo.	25. DATE RECD. BY LOCAL REG. 11-17-58	26. REGISTRAR'S SIGNATURE Herbert R. Domke MD
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Leslie Welch*

Licensed Embalmer No. *4395*

P. O. Address *Woburn, Mass.*

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.