THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003442

State File No. .....

FEB 10 1959

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. 2 866

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ST. LOUIS
c. LENGTH OF STAY (in this place): 82 YRS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4347 WARNE AVE

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY: /
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ST. LOUIS
d. STREET ADDRESS (If rural, give location): 2099 4347 WARNE AVE

3. NAME OF DECEASED (Type or Print)
a. (First): MARY
b. (Middle): —
c. (Last): ROGERS

4. DATE OF DEATH (Month) (Day) (Year): JAN 25 1959

5. SEX: F. 1
6. COLOR OR RACE: W.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED 2
8. DATE OF BIRTH: MAY 12, 1876
9. AGE (In years last birthday): 82 — 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): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: NIL
11. BIRTHPLACE (City and State or Foreign Country): ST. LOUIS MO. 6
12. CITIZEN OF WHAT COUNTRY?: U.S.A

13a. FATHER'S NAME: THOMAS STANTON
13b. MOTHER'S MAIDEN NAME: ANN OBRIEN
14. NAME OF HUSBAND OR WIFE: JAMES ROGERS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT'S SIGNATURE OR NAME / ADDRESS: GEORGE ROGERS 4347 WARNE AVE

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma of colon c̄ metastases — INTERVAL BETWEEN ONSET AND DEATH: 7 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c): 153.8

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: arteriosclerotic cardiovascular years disease

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒ 2

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1958, *to* Jan. 25, 1959, *that I last saw the deceased alive on* Jan 24, 1959, *and that death occurred at* 10:40a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Aaron Berenbaum M.D.
23b. ADDRESS: 462 N. Taylor
23c. DATE SIGNED: 1/25/59

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: JAN. 28, 1959
24c. NAME OF CEMETERY OR CREMATORY: CALVARY CEM
24d. LOCATION (City, town, or county) (State): ST. LOUIS, MO

DATE REC'D BY LOCAL REG.: JAN 26 '59
REGISTRAR'S SIGNATURE: J Earl Smith MD MJB
25. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Friedmeyer & Sons 3934 No. 20th

(Licensed Embalmer's Statement on Reverse Side)

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 .....
Student Embalmer

Signed Gustav W. Dietrich

Licensed Embalmer No. 4329

P. O. Address St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.