Health, Welfare Public Service

300
-57
7
391
0

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-007584
STATE FILE NUMBER

FILED FEB 26 1959 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 180

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY

b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Louis — Inside Limits Yes [X] No [ ]

c. CITY OR TOWN St. Louis — Inside Limits Yes [X] No [ ]

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Chronic Hosp. — Length of stay in 1b 27½ yrs.

d. STREET ADDRESS (If outside, give location) 5800 Arsenal St. — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First Fred Middle Last Rodgers

4. DATE OF DEATH Month Day Year 1-2-59

5. SEX male 0

6. COLOR OR RACE white

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] 2 DIVORCED [ ]

8. DATE OF BIRTH 10-1-79

9. AGE (In years last birthday) 79 — 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) unknown

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) Ill. 1

12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Wm. Rodgers

13b. MOTHER'S MAIDEN NAME Laura Sexton

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)

16. SOCIAL SECURITY NO.

17. INFORMANT Address Public Administrator, Civil Cts. Bldg.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized Adenocarcinomatosis — INTERVAL BETWEEN ONSET AND DEATH 6 mo.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c) Adenocarcinoma of Bile Duct — 6 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 155.1

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ] 1

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 4-16-31, to 1-2-59 and last saw her/him alive on 1-2-59
Death occurred at 3:55 a.m. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) John W. Beckham, M.D.

22b. ADDRESS 5800 Arsenal

22c. DATE SIGNED 1/2/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Creamation

23b. DATE 1/8/1959

23c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory

23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.

24. FUNERAL DIRECTOR ADDRESS Morrell Mortuary 3710 North Grand

25. DATE RECD. BY LOCAL REG. JAN 7 '59

26. REGISTRAR'S SIGNATURE J. Earl Smith MD MJB

(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

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 Leon E. Percy

Licensed Embalmer No. 4094

P. O. Address St. Louis, Mo.

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.