

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011639
STATE FILE NUMBER

APR 6 1959 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 894

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|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY ST Louis | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY ST Louis | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CLAYTON | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN WELLSTON |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION COUNTY Hosp. | | Length of stay in lb 12 DAYS | d. STREET ADDRESS (If outside, give location) 6402 SUBURBAN |
| | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|--|----------------------------------|--|--|--|--|
| 3. NAME OF DECEASED (Type or print) First CHARLES Middle ROHLFING Last | | | 4. DATE OF DEATH Month 3 Day 31 Year 1959 | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH SEPT. 15, 1882 | | 9. AGE (In years last birthday) 76 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHIROPRACTOR | | 10b. KIND OF BUSINESS OR INDUSTRY MEDICAL | 11. BIRTHPLACE (City and state or country) WASHINGTON Co. ILL. | | 12. CITIZEN OF WHAT COUNTRY? USA |

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|--|--|---|--|---|--|
| 13a. FATHER'S NAME CHRIS ROHLFING | | 13b. MOTHER'S MAIDEN NAME MARY GEISEL | | 14. NAME OF HUSBAND OR WIFE EMMA ROHLFING | |
| 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. unk. | 17. INFORMANT MR WALTER ROHLFING Address 6402 SUBURBAN | | |

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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) Generalized Cacinomatosis | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Primary Site Undetermined | | |
| DUE TO (c) | | |
| 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"/> 2 |

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|---|--|--|---|--|--------------|
| 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.) 1992 | | |
| 20c. TIME OF INJURY Hour a.m. Month, Day, Year 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 |

21. I attended the deceased from **3-21-1959** to **3-31-1959** and last saw ^{her} _{him} alive on **3-31-1959**
Death occurred at **10:30p** on the date stated above; and to the best of my knowledge, from the causes stated.

| | | |
|---|---|-----------------------------------|
| 22a. SIGNATURE J. A. Brennan, Jr. M.R. (I agree or title) | 22b. ADDRESS 601 S. Brentwood Blvd. | 22c. DATE SIGNED 4-1-59 |
|---|---|-----------------------------------|

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|---|---------------|------------------------------------|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City, town, or county) (State) |
| BURIAL | 4-3-59 | MEMORIAL PARK. | ST Louis Co. MO |

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|--|------------------------------|---|--|
| 24. FUNERAL DIRECTOR DREHMANN-HARRAL | ADDRESS 1905 UNION | 25. DATE RECD. BY LOCAL REG. 4-2-59 | 26. REGISTRAR'S SIGNATURE John C. Murphy, M.D. |
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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-57

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 *Albert R. Thompson*

Licensed Embalmer No. *4237*

P. O. Address *St. Louis*

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.