

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015631

STATE FILE NUMBER

2 4081

FILED MAY 15 1959

Registration District No. _____

Primary Registration District No. _____

Registrar No. _____

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1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kirkwood 4683</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>821 N. Clay Ave.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>EVALYN</u> Middle <u>P.</u> Last <u>ROGERS</u>			4. DATE OF DEATH Month <u>APRIL</u> Day <u>24</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 17, 1900</u>		9. AGE (In years last birthday) <u>58</u> 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) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Meadeville, Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Frederich W. Peirson</u>		13b. MOTHER'S MAIDEN NAME <u>Eva McGill</u>		14. NAME OF HUSBAND OR WIFE <u>John W. Rogers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>John W. Rogers-821 N. Clay Ave.</u> Address <u>Kirkwood, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>STAPHYLOCOCCAL SEPTICEMIA</u>					INTERVAL BETWEEN ONSET AND DEATH <u>36 HOURS</u>
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last. } DUE TO (b) <u>STAPHYLOCOCCAL ABSCESSSES</u>					<u>4 DAYS</u>
DUE TO (c) <u>EXFOLIATIVE DERMATITIS</u>					<u>4 YEARS</u>
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"/> <u>2</u>
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 _____ 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	
21. I attended the deceased from <u>MARCH 1, 1959</u> to <u>APRIL 24, 1959</u> and last saw ^{her} / _{him} alive on <u>APRIL 24, 1959</u> Death occurred at <u>8:30 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>E. O. Vermillion, M.D.</u> (Degree or title) <u>0</u>			22b. ADDRESS <u>BARNES HOSPITAL</u>		22c. DATE SIGNED <u>4/24/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Apr. 27, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Kirkwood 22, Mo.</u>
24. FUNERAL DIRECTOR <u>Pfzitinger Mort-Kirkwood 22, Mo.</u> ADDRESS			25. DATE RECD. BY LOCAL REG. <u>APR 27 '59</u>		26. REGISTRAR'S SIGNATURE <u>Neal Smith M.D.</u>

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 *Ben E. Hooper*
Licensed Embalmer No. *14368*
P. O. Address *Mauro*

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.