

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015633

STATE FILE NUMBER

2 2878

FILED MAY 1 1959

Registration District No. _____ Primary Registration District No. _____

Registrar No. _____

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1-57

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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer Phillips		d. STREET ADDRESS 5334 Theodosia Ave.	
Length of stay in 1b 1 wk.		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Hosp. Middle M. Last Rogers			4. DATE OF DEATH Month 3 Day 20 Year 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 12, 1881
9. AGE (In years last birthday) 77	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist - Ret.	11. BIRTHPLACE (City and state or country) Champaign Co. Ill.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Wm. A. Rogers		14. NAME OF HUSBAND OR WIFE Gladys Anna Rogers	
13b. MOTHER'S MAIDEN NAME Susan Frame		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. 496-14-7023		17. INFORMANT Address Mr. Lloyd C. Dunham, Chicago, Ill.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural Hemorrhage DUE TO (b) Multiple Fractures DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS (Do not include in (a), (b), or (c) above) depressed skull fracture, skull base fracture, operated by craniotomy			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. TYPE AND NATURE OF INJURY OCCURRED (Enter nature of injury in PART I or in full of item 18.) craniotomy of base and skull base, about 39 p.m. March 14, 1959.		
20c. TIME OF INJURY 6:39 p.m. 3 14 59	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		
20e. CITY, TOWN, OR LOCATION St Louis	20f. COUNTY STATE Mo		
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at 9:30 a m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Gabriel F. Taylor, Coroner		22b. ADDRESS 1300 Clark	
22c. DATE SIGNED 3.21.59			
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 3/22/59	23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery	23d. LOCATION (City, town, or county) (State) County of Champaign Ill.
24. FUNERAL DIRECTOR Drehmann-Harral		25. DATE RECD. BY LOCAL REG. MAR 21 '59	26. REGISTRAR'S SIGNATURE Roan Smith, M.D.
ADDRESS 1905 Union			

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 *Robert P. Thompson*

Licensed Embalmer No. *4237*

P. O. Address

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.