THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-019448
STATE FILE NUMBER

FILED JUN 1 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 4742

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St. Louis, Mo. — Inside Limits: Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION: 5419 Blow — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 5419 Blow — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Emma — Middle: Molly — Last:

4. DATE OF DEATH: Month May — Day 13 — Year 1959

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Sept. 20, 1875

9. AGE (In years last birthday): 83 — 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: at Home

11. BIRTHPLACE (City and state or country): Germany

12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Oscar Roegner

13b. MOTHER'S MAIDEN NAME: Hermenia Cooke

14. NAME OF HUSBAND OR WIFE: Edw. P. Molly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: unk

17. INFORMANT: Mrs. Lena Callahan — Address:

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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): Cerebro Vascular Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 week
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Hypertension — ? yrs.
DUE TO (c): Generalized Arteriosclerosis — ? yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 331x

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

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 5-3-59 to 5-13-59 and last saw her/him alive on 5-11-59
Death occurred at 1145 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Albert Kaplan M.D.

22b. ADDRESS: 607 N. Grand

22c. DATE SIGNED: 5-15-59

23a. BURIAL, CREMATION, REMOVAL (Specify): removal

23b. DATE: 5-16-59

23c. NAME OF CEMETERY OR CREMATORY: Mt. Hope Cem.

23d. LOCATION (City, town, or county) (State): Lemay 23, Mo.

24. FUNERAL DIRECTOR — ADDRESS: Southern Funeral Home, 6322 S. Grand, St. Louis, Mo.

25. DATE RECD. BY LOCAL REG.: MAY 15 '59

26. REGISTRAR'S SIGNATURE: Earl Smith, M.D. MJB

(Licensed Embalmer's Statement on Reverse Side)

Dr A. Kaplan
~~[illegible]~~
University Club Bldg
9 to 1 PM

12 3/
9 to 1

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 David Van Fossan

Licensed Embalmer No. 4242

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.