Health, & Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-019570
STATE FILE NUMBER

FILED MAY 18 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 4423

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St. Louis — Inside Limits Yes XX No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital or institution, give street address): St. Louis Children's Hospital — Length of stay in Hospital: 6 days

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: 1343 Montclair (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First Janice Middle Louise Last Rogers
4. DATE OF DEATH: Month May Day 1 Year 1959
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 10.1953
9. AGE (In years last birthday): 6yrs — 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): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (City and state or country): St. Louis Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME: John Matthew Rogers
13b. MOTHER'S MAIDEN NAME: Doris Diggs
14. NAME OF HUSBAND OR WIFE: None
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Jane Henrichsen — Address: 500 s Kingshighway

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hemorrhage into ventricular wall — INTERVAL BETWEEN ONSET AND DEATH: 27 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Post-op repair IV septal defect — 27 hrs.
DUE TO (c) Cong. heart disease - TVSD — Life
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 754.2
19. WAS AUTOPSY PERFORMED? YES XX 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 4-25-59, to 5-1-59 and last saw her/him alive on 5-1-1959
Death occurred at 3:12pm m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Richard Spitz (Degree or title) M.D. — Richard Spitz M.D.
22b. ADDRESS: 500 S. Kingshighway
22c. DATE SIGNED: 5-1-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: MAY 6-59
23c. NAME OF CEMETERY OR CREMATORY: St. Peters Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis County Mo.

24. FUNERAL DIRECTOR: Wm. Smith — ADDRESS: 4019 Washington
25. DATE RECD. BY LOCAL REG.: MAY 5 '59
26. REGISTRAR'S SIGNATURE: Karl Smith M.D.

(Licensed Embalmer's Statement on Reverse Side)

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 .....

Licensed Embalmer No. 4371

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.