

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023343

STATE FILE NUMBER

FILED JUL 1 1959 Registration District No. Primary Registration District No. Registrar No. 5828

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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 <u>MISSOURI</u> b. COUNTY _____					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>ST. LOUIS</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>FIRMIN-DESLOGE-HOSP. LIFE</u>			Length of stay in 1b <u>LIFE</u>		d. STREET ADDRESS (If outside, give location) <u>1419-NO. 8TH ST (APT. 807)</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle _____ Last <u>ROHDE</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>17</u> Year <u>1959</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEP. 28TH 1884</u>		9. AGE (In years last birthday) <u>74 YRS.</u> Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FORMERLY-SUPERVISOR</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>MIDWEST-LAUNDRY</u>		11. BIRTHPLACE (City and state or country) <u>ST. LOUIS-MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13a. FATHER'S NAME <u>CHARLES-ROHDE</u>			13b. MOTHER'S MAIDEN NAME <u>MARY-HEMPEN</u>			14. NAME OF HUSBAND OR WIFE <u>NEVER-MARRIED</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO NONE</u>			16. SOCIAL SECURITY NO. <u>488-10-0442</u>		17. INFORMANT Address <u>CHARLES-ROHDE-1543-VERONICA-AV</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>Cerebral Thrombosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>12 day</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) _____		DUE TO (c) _____		332x			
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"/>		
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 <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 <u>ST. LOUIS</u>		COUNTY _____		STATE _____		
21. I attended the deceased from <u>6/5/59</u> to <u>6/17/59</u> and last saw her ^{him} alive on <u>6/16/59</u> Death occurred at <u>10:130 A. M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>E. Kleinschmidt</u> (Degree or title)				22b. ADDRESS <u>508 N. Grand</u>			22c. DATE SIGNED <u>6/18/59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>JUNE-20-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY-CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS - MO.</u>			
24. FUNERAL DIRECTOR <u>Brockland Und Co. 1827-HOGAN-ST</u>				25. DATE RECD. BY LOCAL REG. <u>JUN 19 '59</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>			

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 *J. W. Embrey*

Licensed Embalmer No. *3653*

P. O. Address *M. Lewis & Co.*

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.