

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023345

STATE FILE NUMBER

2 5721

11 JUL 1 1959 Registration District No. Primary Registration District No. Registrar No.

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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>Mo.</u> b. COUNTY <u>Jefferson</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>Festus</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 <u>2 weeks</u>	d. STREET ADDRESS (If outside, give location) <u>304 S. Fourth</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES Monroe ROLPH</u>			4. DATE OF DEATH Month Day Year <u>JUNE 15, 1959</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>Apr. 26, 1883</u>
9. AGE (In years if UNDER 1 YEAR; if UNDER 24 HRS. list birthday) Months Days Hours Min. <u>76</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Glass worker</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Plate Glass</u>
11. BIRTHPLACE (City and state or country) <u>River Sioux, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Monroe A. Rolph</u>		13b. MOTHER'S MAIDEN NAME <u>Emma Smith</u>	
14. NAME OF HUSBAND OR WIFE <u>Margaret Hooper Rolph</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Mrs. Margaret Rolph, 504 S. 4th</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>ADENOCARCINOMA OF RECTUM WITH METASTASES</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 YEARS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>154x</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>UREMIA OF UNKNOWN CAUSE</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 Month, Day, Year 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>JUNE 1, 1959</u> to <u>JUNE 15, 1959</u> and last saw her/him alive on <u>JUNE 15, 1959</u> Death occurred at <u>8:30 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>F. R. Bradley M. D.</u>		22b. ADDRESS <u>BARNES HOSPITAL</u>	22c. DATE SIGNED <u>6/16/59</u>
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>June 19, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Methodist</u>	23d. LOCATION (City, town, or county) (State) <u>Festus, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Vineyard Funeral Home Festus, Mo</u>		25. DATE RECD BY LOCAL REG. <u>JUN 16 '59</u>	26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>

JUL 15 1970

MISSOURI DEPARTMENT OF HEALTH

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 *Donald H. Vinyard*

Licensed Embalmer No. *4608*

P. O. Address *Festus, 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 licensę).
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.