RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS FEB 23 1960

[redacted]

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 1561 STATE FILE NUMBER 60-008792

NDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Length of stay in 1b: 82 months
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Bethesda Hospital — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY:
c. CITY OR TOWN: St. Louis — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 1444a DeSoto Ave. — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: STEPHEN Middle: MICHAEL Last: ROGERS
4. DATE OF DEATH: Month: Feb. Day: 8 Year: 1960
5. SEX: male
6. COLOR OR RACE: white
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 8/7/1946
9. AGE (last birthday): 13 — IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HR: 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:
11. BIRTHPLACE (City and state or country): St. Louis Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Russell Rogers
13b. MOTHER'S MAIDEN NAME: Rose Mary Brennan
14. NAME OF HUSBAND OR WIFE:
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: James Schroeder 1444a DeSoto Ave. Address

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): BRONCHOPNEUMONIA
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): CEREBRAL PALSY
DUE TO (c): 334x
INTERVAL BETWEEN ONSET AND DEATH:
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown
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 Feb 1, '60, to Feb 8 '60 and last saw her/him alive on Feb 8, 1960
Death occurred at 9:20 PM m on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title): Dionne T. Y Shey MD
22b. ADDRESS: 1695 S. BRENTWOOD D, ST. LOUIS
22c. DATE SIGNED: Feb 9 '60

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE: 2/11/1960
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county): St. Louis (State): Mo.
24. FUNERAL DIRECTOR: Buchholz Mortuary ADDRESS: 5967 W. Florissant
25. DATE RECD. BY LOCAL REG.: FEB 10 1960
26. REGISTRAR'S SIGNATURE: Joan Smith, M.D. MDB

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

Burial - No Cemetery - death certificate not filed Corrected Tel

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed V E Morris

Licensed Embalmer No. 336

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co
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.