

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 7 1960

60-025186

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 548 Registrar's No. 1860

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>ST. LOUIS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>WEBSTER GROVES</b>	Length of stay in 1b <b>YRS.</b>	c. CITY OR TOWN <b>WEBSTER GROVES</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>420 YORKSHIRE PLACE</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>420 YORKSHIRE PLACE</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>ELIJAH COLMORE ROGERS</b>			4. DATE OF DEATH Month Day Year <b>JUNE 16, 1960</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2/9/1886</b>	9. AGE (last birthday) <b>74</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DRY GOODS</b>		11. BIRTHPLACE (City and state or country) <b>EASTON, MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>JOSEPH LAWSON ROGERS</b>		13b. MOTHER'S MAIDEN NAME <b>ALENA MC CRARY</b>		14. NAME OF HUSBAND OR WIFE <b>ELIA BOYD ROGERS</b>		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES W.W.I</b>	16. SOCIAL SECURITY NO. <b>489-12-1350</b>	17. INFORMANT Address <b>MRS. ALLAN GOODLOE, 108 SO. ROCK HILL</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>EPIDERMOID CARCINOMA OF THE BLADDER</b>		INTERVAL BETWEEN ONSET AND DEATH <b>11 year</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	

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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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. Month, Day, Year			
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 **8:50 P.M. 6/16/60** to **6/16/60** and last saw him **2x** alive on **6/7/60**  
Death occurred at \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Hugh S. Waters</b> (Degree or title)		22b. ADDRESS <b>M.D. 600 Union Blvd. St. Louis 8</b>		22c. DATE SIGNED <b>6/17/60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>6-18-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>OAK HILL CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>KIRKWOOD, MO.</b>	

24. FUNERAL DIRECTOR ADDRESS <b>PARKER-ALDRICH, WEBSTER GROVES, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>6-17-60</b>	26. REGISTRAR'S SIGNATURE <b>J. C. Murphy M.D.</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Leslie Holch

Licensed Embalmer No. 4395  
P. O. Address Abster St

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.