MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

23082

1. PLACE OF DEATH

County ..... Registration District No. 791 1003

Township ..... Primary Registration District No. .....

City St. Louis, Mo. (No. Lutheran Hospital St. ..... Ward)

File No. .....

Registered No. 6527

2. FULL NAME William H. Rockwell

(a) Residence. No. 3323 Iowa Ave. St., 24 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 20-1862

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
66	8	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Ice Business
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis, Mo.

PARENTS

10. NAME OF FATHER Dan Rockwell

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) New York

12. MAIDEN NAME OF MOTHER Elizabeth Lauder

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ireland

14. INFORMANT Emma Rockwell, (Address) 3323 Iowa Ave.

15. FILED JUN 18 1929 Max C. Tarkert REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 16- 1929.

17. I HEREBY CERTIFY, That I attended deceased from June 15- 1929, to June 16, 1929 that I last saw him alive on June 16, 1929 and that death occurred, on the date stated above, at 11:50 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Hepatitis
Severe Icterus -

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (SECONDARY) Myocarditis Chronic

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No. DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) Cleveland H. Shutt, M. D.

6/17, 1929. (Address) 305 Metropolitan Bldg.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
New St. Marcus,	6-19- 1929.
20. UNDERTAKER	ADDRESS
Ziegenhein Bros. 2623 Cherokee St.	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

160