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MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 34270

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 8967

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH  
(a) County St Louis Mo  
(b) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Firmin Desloge Hosp  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community Life years, months or days

8. (a) PRINT FULL NAME Anna C Rolfe  
8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased 2-25-1861 (Month) (Day) (Year)

8. AGE: Years 79 Months 8 Days 5 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace St Louis Mo (City, town, or county) (State or foreign country)

10. Usual occupation House work

11. Industry or business \_\_\_\_\_  
12. Name Henry H Rolfe  
13. Birthplace Germany (City, town, or county) (State or foreign country)  
14. Maiden name Adelaide Ledike  
15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant Miss Adelaide Rolfe  
(b) Address 5551 St Louis Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-2-40 (Month) (Day) (Year)  
(c) Place: burial or cremation St Peter & Paul Cem.

18. (a) Signature of funeral director SULLIVAN Bros  
(b) Address 7849 No Euclid Ave

19. OCT 31 1940 (Date received local authority) (b) J. F. Buehler (Signature of Registrar)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis, Mo (If outside city or town limits, write "RURAL.")  
(d) Street No. 5551 St Louis Ave (If rural, give location)  
(e) If foreign born, how long in U. S. A.? Life years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 10-30-40 day \_\_\_\_\_ year \_\_\_\_\_ hour 10:30 AM, minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from 10-12-40 to 10-30-40, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinomatous Primary site unknown  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) 52

PHYSICIAN  
Major findings: Of operations \_\_\_\_\_  
Of autopsy Carcinoma  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place) (or means of injury)  
23. Signature Dr. W. D. Flynn (M. D. or other) \_\_\_\_\_  
Address Firmin Desloge Date signed 10-31-40

**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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Al. Mayfield

Licensed Embalmer No. 3077

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**