

Registration District No. **7911** Primary Registration District No. **1003**

FILED DEC 11 1940

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 Days (Specify whether
In this community Life (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Edward Rollberg

3. (b) If veteran, name war ---- 3. (c) Social Security No. 499-01-6079

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Lida Rollberg 6. (c) Age of husband or wife if alive ---- years

7. Birth date of deceased February 14 1882
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>58</u>	<u>8</u>	<u>17</u>	hr. _____ min.

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

10. Usual occupation Laborer

11. Industry or business _____

MOTHER FATHER { 12. Name John Rollberg

13. Birthplace Unknown Germany
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant June Stockamp

(b) Address 2011a N. Broadway

17. (a) Burial (b) Date thereof 11/6/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Park Lawn Cemetery

18. (a) Signature of funeral director Wacker-Walderte
(b) Address NOV 23 1940 Broadway

19. (a) _____ (b) J. F. Bredet
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis (If outside city or town limits, write "RURAL")

(d) Street No. 2819 N. 11th St. (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 3, year 1940 hour 3:25 minute _____ P. M.

21. I hereby certify that I attended the deceased from October 27, 1940 to November 3, 1940;

that I last saw him alive on November 3, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death: Suppurative heart disease
Pulmonary infarction
Paralysis

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy: suppurative aortic
chronic hypertrophy
pulmonary infarction

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) (e) Means of injury _____

23. Signature M. M. Karl (M. D. or other) _____
Address 1515 Lafayette Avenue Date signed 11/4/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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 Robert Wheeler

Licensed Embalmer No. 2128

P. O. Address Stoughton

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 this body is not embalmed, fact should be so stated above.