

STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No.

Registration District No.

318

Primary Registration District No.

1003

7346

1. PLACE OF DEATH:

(a) County.....  
(b) City or town **St. Louis**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution **Jewish Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
In this community.....  
years, months or days

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. **5941 Washington**  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME

**Nellie May Rohlfing**

3. (b) If veteran, name war.....  
**No**

3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **Senter Rohlfing** 6. (c) Age of husband or wife if alive **48** years  
7. Birth date of deceased **October 30 1895**  
(Month) (Day) (Year)

8. AGE: Years **50** Months **9** Days **21** If less than one day hr. min.

9. Birthplace **Anna Illinois**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

12. Name **Frank Gallegly**  
13. Birthplace **Anna Illinois**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Ethel Jean**  
15. Birthplace **Anna Illinois**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Senter Rohlfing**  
(b) Address **5941 Washington**

17. (a) **Burial** (b) Date thereof **8-24-46**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Albert H. Hoppe**  
(b) Address **4700 Washington Blvd.**

19. (a) **AUG 23 1946** (Date received local registrar)  
**J. F. Brebeck** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **21** year **46** hour **3** minute **50 P.M.**  
21. I hereby certify that I attended the deceased from **June 3** 19**46** to **Aug 21** 19**46**  
that I last saw him alive on **Aug 21** 19**46** and that death occurred on the date and hour stated above.

Immediate cause of death **Abscess of brain Non-tubercular**  
Duration **2 mo.**

Due to **ant anti bacterial and carditis**  
Due to **ant anti bacterial and carditis**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **91**  
Of autopsy **abscess of brain meningitis ant anti bacterial and carditis**  
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?.....

(Specify type of place) While at work?..... (e) Means of injury.....  
23. Signature **Joseph Magidson** (M. D. or other) **MD**  
Address **520 W. 10th** Date signed **8-23-46**

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

MOTHER FATHER

