

No. 2  
-12-45  
5-17-39  
I X47070

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

11465

State File No. ....

FILED APR # 18 1947

Registration District No. 318

Primary Registration District No. 1002

Registrar's No. 2200

1. PLACE OF DEATH:

(a) County..... St. Louis, Missouri.

(b) City or town..... St. Louis, Missouri.

(c) Name of hospital or institution: St. Louis City Hospital - Max C. Starloff Memorial  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... premature infant (Specify whether 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. 2606 Dekalb St.,  
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Infant BABY GIRL ROGGE

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex female / 5. Color or race white 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 January 31st, 1947  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
3 days hr. min.

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

10. Usual occupation..... nil

11. Industry or business..... nil

MOTHER FATHER

12. Name Bernard Rogge

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

14. Maiden name Eulah Owens

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

16. (a) Informant M. Renard  
(b) Address Anatomical Dept St. Louis City Hospital

17. (a) (Burial, cremation, or removal) (b) Date thereof 3-4-47  
(Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....  
(b) Address 3500 Rutledge

19. (a) MAR 28 1947 (Date received local registrar) (b) J. F. Brecker (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 28th  
year 1947 hour 4:50 minute A M.

21. I hereby certify that I attended the deceased from 1/31/47 to 2/28/47  
and that death occurred on the date and hour stated above.

Immediate cause of death Premature Infant  
Died in utero  
undetermined

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death) 119

Major findings:  
Of operations.....  
Of autopsy.....

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? 805 Lafayette  
23. Signature 1515 Lafayette (2/28/47)  
Address Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**