

No. 30-10-47
5-17-39
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FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED AUG 13 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **250480**
Registrar's No. _____

Registration District No. **317**

Primary Registration District No. **6076**

1. PLACE OF DEATH:

(a) County **St. Louis**

(b) City or town **Ellisville**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Sunset Sanatorium**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether in this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**

(c) City or town **University City**
(If outside city or town limits, write "RURAL")

(d) Street No. **1016 Roth Ave.**
(If rural, give location)

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

3. (a) PRINT FULL NAME **Charles A. Rohlfing Sr.**

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

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

4. Sex **Male**

5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Louise Rohlfing**

6. (c) Age of husband or wife if alive **70** years

7. Birth date of deceased **July 29 1868**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **29** year **1948** hour **7** minute **45 P. M.**

21. I hereby certify that I attended the deceased from **July 11 1948** to **July 28 1948**

that I last saw him alive on **July 28 1948** and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Myocarditis**

8. AGE: Years **80** Months **0** Days **0**
If less than one day hr. min.

9. Birthplace **New Melle Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Grocer**

Duration _____

Due to **Arteriosclerosis**
Chronic nephritis

Due to **1-3/4**

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

MOTHER FATHER

11. Industry or business _____

12. Name **Unknown**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Clarence Rohlfing**

(b) Address **1016 Roth Ave.**

17. (a) **Burial** (b) Date thereof **8-2-48**
(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) **8-2-48** (b) **George A. Hoppe**
(Date received local registrar) (Registrar's signature)

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN

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) (e) Means of injury _____

23. Signature **Henry F. Scott** (M. D. or other) **M.D.**

Address **Baltimore Md** Date signed **Aug 30-48**

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 *Frank J. O'Hara*
.....
..... Licensed Embalmer No. *2675*
.....
..... P. O. Address *St Louis Mo*
.....

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.