

FILED JUL 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 21594

318

1003

Registrar's No. 5478

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| BIRTH NO. | | REG. DIST. NO. | | PRIMARY REG. DIST. NO. | | Registrar's No. | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE | | | | b. COUNTY | | | | | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | | | c. LENGTH OF STAY (in this place) | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | | | | | | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 2903 Indiana - Ave. | | | | d. STREET ADDRESS (If rural, give location) 2903 Indiana Ave. | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or Print) | | | a. (First) | | | b. (Middle) | | | c. (Last) | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| Hubert | | | Ronald | | | Rockwell | | | June | | | 24, 1949 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | | 8. DATE OF BIRTH March 13, 1864 | | 9. AGE (In years last birthday) 85 | | IF UNDER 1 YEAR Months 3 | | IF UNDER 1 HR. Day 11 | | IF UNDER 1 MIN. Hour | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician-Retired | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) Bowling Green, Kentucky | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13a. FATHER'S NAME William T. Rockwell | | | | 13b. MOTHER'S MAIDEN NAME Not known | | | | 14. NAME OF HUSBAND OR WIFE Ida May | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT'S SIGNATURE OR NAME William T. Rockwell | | | | ADDRESS 2862a S. Jefferson Ave. | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Coronary thrombosis DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19a. DATE OF OPERATION | | | | 19b. MAJOR FINDINGS OF OPERATION | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis, Mo. | | | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) | | | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21f. HOW DID INJURY OCCUR? H201 | | | | | | | |
| 22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 4:55 P.M. , from the causes and on the date stated above. | | | | | | | | | | | | | | | |
| 23a. SIGNATURE (Degree or title) Joseph M. ... | | | | | | 23b. ADDRESS 1300 Clark | | | | 23c. DATE SIGNED 6/25/49 | | | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE June 27, 1949 | | 24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery | | | | 24d. LOCATION (City, town, or county) (State) St. Louis, County, Mo. | | | | | | | |
| DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JUN 25 1949 J. B. Kasater | | | | 25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS John H. Gebken Sons and Co., 2500 Gravois Ave. | | | | | | | | | | | |

WRITE PLAINLY—USING 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.....

..... Student Embalmer No.

working under my personal supervision.

Signed.....
Student Embalmer

Signed

Van M. Sizemore

Licensed Embalmer No. **4343**

P. O. Address **4104 Manchester Ave.**

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, fact should be so stated above.