

FILED JUL 26 1954

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

22294

State File No.

BIRTH NO. _____ REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 213

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St Charles</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Fulton</u>		c. CITY OR TOWN <u>St Charles</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>29 yrs</u>		e. STREET ADDRESS (If rural, give location) <u>0427</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital No 1</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Emma</u> b. (Middle) <u>L</u> c. (Last) <u>Rohlfing</u>		4. DATE OF DEATH (Month) <u>July</u> (Day) <u>21</u> (Year) <u>1954</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>OK approx</u>
9. AGE (In years last birthday) <u>84</u>		10. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OK</u>	
11. BIRTHPLACE (City and State or Foreign Country) <u>America</u>		12. COUNTRY OF WHAT COUNTRY? <u>U.S</u>	

13a. FATHER'S NAME <u>OK</u>	13b. MOTHER'S MAIDEN NAME <u>OK</u>	14. NAME OF HUSBAND OR WIFE <u>OK</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>OK</u>	17. INFORMANT'S SIGNATURE OR NAME <u>State Hosp #1 Records Fulton Mo</u>	ADDRESS _____
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchopneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES <u>Generalized Arteriosclerosis</u> Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> <u>1500</u>
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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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 9, 1954, to July 21, 1954, that I last saw the deceased alive on July 21, 1954, and that death occurred at 4:48 P. m., from the causes and on the date stated above.

23a. SIGNATURE <u>J. K. Hunter</u> (Degree or title) <u>M.D.</u>	23b. ADDRESS <u>Fulton Mo</u>	23c. DATE SIGNED <u>July 21/54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>July 24/54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St Charles Mo</u>
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DATE REC'D BY LOCAL REG. <u>July 24-1954</u>	REGISTRAR'S SIGNATURE <u>Martha Lawrence</u>	4265	25. FUNERAL DIRECTOR'S SIGNATURE <u>Monipier & N. Fulton Mo</u>	ADDRESS _____
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WRITE PLAINLY—USING UNFAADING 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, Student Embalmer No. working under my personal supervision:.

Student.....
Signature of Student Embalmer

Signed *J. D. Passon*.....
Licensed Embalmer No. *2555*
P. O. Address *Fullon*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.