

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-15637

STATE FILE NUMBER

Registration District No. 2 Registrar No. 3264

FILED APR 20 1959

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar No. \_\_\_\_\_

300  
1-57  
19  
0

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jewish Hospital</u> Length of stay in 1b _____		d. STREET ADDRESS <u>2853 Eads Ave.</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>W.</u> Last <u>ROHLFING</u>			4. DATE OF DEATH Month <u>Mar.</u> Day <u>31</u> Year <u>1959</u>		
---	--	--	--	--	--

5. SEX <u>Male</u> <u>0</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> <u>0</u> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 10, 1884</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
--------------------------------	----------------------------------	--	--	--	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman (Salesman)</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Stix, Baer &amp; Fuller Co.</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
---	---	---	---

13a. FATHER'S NAME <u>William Rohlfling</u>	13b. MOTHER'S MAIDEN NAME <u>Sophia Brettholle</u>	14. NAME OF HUSBAND OR WIFE -----
--	---	--------------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>	16. SOCIAL SECURITY NO. <u>488-03-5022</u>	17. INFORMANT <u>Hulda Rohlfling 117 Waverly</u> Address _____
---	---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, Prostate</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>177X</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>metastases, Femurs, Ribs</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---	--

20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
---	---	--	--

21. I attended the deceased from <u>June 10, 1949</u> to <u>Mar 31, 59</u> and last saw <u>him</u> alive on <u>3/31/59</u> Death occurred at <u>7:00 P.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.
---

22a. SIGNATURE (Degree or title) <u>Norman W. Deay M.D.</u>	22b. ADDRESS <u>634 N. Grand</u>	22c. DATE SIGNED <u>4/1/59</u>
--	-------------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Apr. 3, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Picker Cemetery</u>	23d. LOCATION (City, town, or county) <u>St. Louis, Mo.</u>
--	----------------------------------	--	--

24. FUNERAL DIRECTOR <u>Kriegshauser 4228 S. Kingshighway</u> ADDRESS _____	25. DATE RECD. BY LOCAL REG. <u>APR 1 '59</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith M.D.</u>
---	--	---

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *William B. White* .....

Licensed Embalmer No. *4291* .....  
P. O. Address *428 So. Kingsley* .....

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.