

JUN 5 1936

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

20761

1. PLACE OF DEATH

County.....  
Township.....  
City..... *St. Louis Mo*

Registration District No. **791**  
Primary Registration District No. **1003**  
(No. *Barnes Hospital*)

File No.....  
Registered No. **4947**  
St. .... Ward)

2. FULL NAME

*William Rosen*

(a) Residence, No. *4039 1/2 Shaw* St. *17* Ward.

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male*  
4. COLOR OR RACE *white*  
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *married*  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Fannie Rosen*  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Dec 15 - 1874*  
7. AGE YEARS MONTHS DAYS if LESS than 1 day, ..... hrs. or ..... min.  
*61 4 21*

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Merchant*  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *Dry Goods*  
10. Date deceased last worked at this occupation (month and year).....  
11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Russia*

13. NAME *Hyman Rosen*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Russia*

15. MAIDEN NAME *Ele Bessisen*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Russia*

17. INFORMANT *Fannie Rosen*  
(ADDRESS) *4039 1/2 Shaw av.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Barnesh Hagodal* DATE *5-7* 19*36*

19. UNDERTAKER *H. Rindarkoff*  
(ADDRESS) *5216 Delmar Blvd.*

20. FILED *J. F. Bredeck*  
*MAY 6 - 1936* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *5 - 6 - 1936*

22. I HEREBY CERTIFY, That I attended deceased from *4 - 29 - 1936*, to *5 - 6 - 1936*.  
I last saw him alive on *5 - 6 - 1936*. Death is said to have occurred on the date stated above, at *6 a.* m.

The principal cause of death and related causes of importance were as follows:

*Crown Thrombosis*

Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur? (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed) *Paul Kuebel* M. D.

(Address) *Barnes Hospital*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

