

REC'D APR 17 1936

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

9468
Do not use this space.

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 399
 (b) Township South Primary Registration District No. 1002
 (c) City St. Louis Mo (d) Street No. N. E. Gen Hosp Registered No. 1074
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
 (If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME
 (a) Residence, No. James T. Rose St.
Robert. Hotel (Usual place of abode, if no street address, write county or city) (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) Divorced
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Unknown
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 25 1875
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
63. 8 13
 OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-8-39 19
 22. I HEREBY CERTIFY, That I attended deceased from 12-30-38 19 to 3-8-39 19.
 I last saw him alive on 3-8-39, 19. Death is said to have occurred on the date stated above, at m.
 The principal cause of death and related causes of importance were as follows:
Various abscess Date of onset
right leg; Chronic vas-
cular nephritis B1
 Other contributory causes of importance:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri
 FATHER
 13. NAME Chas. Rose
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland
 MOTHER
 15. MAIDEN NAME Sarah Bush
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky
 17. INFORMANT (ADDRESS) Record Clerk
N. E. Gen Hosp
 18. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Mo
3-9-39
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) John B. Campbell
536 Campbell St
 20. FILED Mar 9 39 M. M. Brown
 Local Registrar.

Pulmonary Embolism
 Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy? yes
 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) O. de Maria M. D.
 (Address) St. X C Gen Hosp
St. Louis Mo

WHILE PLAINLY WRITING INVA... PHYSICIAN'S should state AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1 X1625

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.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.