

BUREAU OF THE CENSUS  
DEC 13 1939

## STANDARD CERTIFICATE OF DEATH

State File No.

9453

Registration District No.

Primary Registration District No.

Registrar's No.

## 1. PLACE OF DEATH:

- (a) County St Louis 2
- (b) City or town St Louis at Home
- (c) Name of hospital or institution: 4433 St Ferdinand  
(If outside city or town limits, write "RURAL" and name of township)
- (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community  
years, months or days3. (a) PRINT  
FULL NAMEJahn Roseborough

## 3. (b) If veteran,

name war \_\_\_\_\_

## 3. (c) Social Security

No. 492-09-3434

## 4. Sex

Male5. Color or  
racecol6. (a) Single, widowed, married,  
divorcedmarried

## 6. (b) Name of husband or wife

Clara Roseborough

## 6. (c) Age of husband or wife if

alive 35 years

## 7. Birth date of deceased

May  
(Month)16  
(Day)1887  
(Year)

## 8. AGE:

Years

Months

Days

If less than one day

52515

hr.

min.

## 9. Birthplace

Columbia  
(City, town, or county)Missouri  
(State or foreign country)

## 10. Usual occupation

Finish molder

## 11. Industry or business

Steel Foundry

## 12. Name

Jahn Roseborough

## 13. Birthplace

Missouri  
(City, town, or county)Missouri  
(State or foreign country)

## 14. Maiden name

unknown

## 15. Birthplace

unknown  
(City, town, or county)unknown  
(State or foreign country)

## 16. (a) Informant's own signature:

Clara Roseborough

## (b) Address

4433 St Ferdinand

## 17. (a)

(b) Date thereof

11 6 39  
(Month) (Day) (Year)

(Burial, cremation, or removal)

## (c) Place: burial or cremation

Washington Park

## 18. (a) Signature of funeral director

R.F. Walton

## (b) Address

2707 Stoddard St

## 19. (a)

NOV 5 1939  
(Date received local registrar)

(b)

J.F. Dudech  
(Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County 1
- (c) City or town St Louis  
(If outside city or town limits, write "RURAL")
- (d) Street No. 4433 St Ferdinand Ave  
(If rural, give location)
- (e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 1  
year 1939 hour 2 minute 30 A. M.

21. I hereby certify that I attended the deceased from July 5-  
1939 to July 1, 1939  
that I last saw him alive on July 1, 1939  
and that death occurred on the date and hour stated above.

## Immediate cause of death

hypertension  
arterial disease

## Duration

5 mo

## Due to

Chronic Nephritis taken

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

## PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically

## 22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) \_\_\_\_\_
- (b) Date of occurrence \_\_\_\_\_
- (c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)
- (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
1

## While at work?

(Specify type of place)

(e) Means of injury \_\_\_\_\_

## 28. Signature

E. E. Moore (M. D. or other)

## Address

809 N. JeffersonDate signed 11/1/39

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.

1-19391

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

*William C. McDowell*

Registered Apprentice No.

working under my personal supervision.

Signed

*William C. McDowell*

Licensed Embalmer No.

*2114*

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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. **37614**  
Registrar's No. **9453**

Registration District No. **791**

Primary Registration District No. **1023**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**1. PLACE OF DEATH:**

(a) County.....  
 (b) City or town..... **St. Louis**  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution.....  
(Specify whether  
 In this community.....  
years months or days)

3. (a) **PRINT FULL NAME**..... **John Roseborough**  
 3. (b) If veteran, name war.....  
 3. (c) Social Security No.....

4. Sex..... **m**..... 5. Color or race..... **col**  
 6. (a) Name of husband or wife..... **Clara Roseborough**  
 6. (c) Age of husband or wife if alive..... years.....  
 7. Birth date of deceased.....  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**52 5 15**..... min.

9. Birthplace.....  
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business..... **ROSEBOROUGH**

12. Name..... **Thos. Roseborough**  
 13. Birthplace.....  
(City, town, or county) (State or foreign country)  
 14. Maiden name.....  
 15. Birthplace.....  
(City, town, or county) (State or foreign country)

16. (a) Informant..... **CLARA ROSEBOROUGH**

(b) Address.....

17. (a)..... (b) Date thereof.....  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) **APR 9 1940** (b) **J. E. Moore**  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State..... (b) County.....  
 (c) City or town.....  
(If outside city or town limits write "RURAL")  
 (d) Street No.....  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.?..... years.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH..... month..... day.....  
 year..... hour..... minute..... M.  
**1939 Nov 1**

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;  
 that I last saw him..... alive on....., 19.....;  
 and that death occurred on the date and hour stated above.

Immediate cause of death.....  
 Due to.....  
 Due to.....  
 Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations.....  
 Of autopsy.....

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify).....  
 (b) Date of occurrence.....  
 (c) Where did injury occur?.....  
(City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
(Specify type of place)

While at work?..... (e) Means of injury.....

23. Signature..... **S. E. Moore** (M. D. or other)  
 Address..... **809 Jefferson** Date signed.....

Duration.....  
**PHYSICIAN**  
 Underline the cause to which death should be charged statistically.

