

Rev. 6-17-39 I x1511

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

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. PLACE OF DEATH:

(a) County St. Louis.

(b) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Infirmary.  
(If not in hospital or institution, write street number and location)

(d) Length of stay: In hospital or institution September 21, 1940  
Life. (Specify whether years, months or days)

3. (a) PRINT FULL NAME 536 Rosalie Sanders.

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased December 29, 1876  
(Month) (Day) (Year)

8. AGE: Years 63 Months 10 Days 9 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation No Occupation

11. Industry or business X

12. Name George Sanders

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

14. Maiden name Rosalie Koester  
(City, town, or county) (State or foreign country)

15. Birthplace Unknown;  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature E. Molony  
(b) Address 5800 Arsenal St.

17. (a) Burial (b) Date thereof 2-10-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Brumshing Mrs. C.  
(b) Address 4746 W. Florissant Ave.

19. (a) FEB 9 1940 (Date received local registrar)  
J. D. Brumshing (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis.

(c) City or town St. Louis, Mo. 13  
(If outside city or town limits, write "RURAL")

(d) Street No. 5800 Arsenal St.  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? American. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 8,  
year 1940 hour 12:20 minute P. M.

21. I hereby certify that I attended the deceased from September 21, 1938 to February 8, 1940  
that I last saw him er alive on February 8, 1940;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac decompensation

Due to Regenerative heart disease

Due to Cellulitis of leg caused by ulcer the same caused by Semblity (varicose veins)

Other conditions Semblity (varicose veins)  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy none 93C

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Paul Maxwell (M. D. or other)  
Address Isolation Hospital Date signed 2/8/40

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically

**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 Guy W Wilkinson

..... Licensed Embalmer No. 3575

..... 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.