

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

39736

State File No.

Registrar's No.

1940

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Koch  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution Robert Koch Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 343 days  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days) 1

3. (a) PRINT FULL NAME

Rose, Earl

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. 189-12-7943

4. Sex M 5. Color or race Negro 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 July 27 1916  
(Month) (Day) (Year)

8. AGE: Years 24 Months 3 Days 11 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Taxi Driver

11. Industry or business Newspaper Office

MOTHER FATHER  
12. Name Samuel Rose  
13. Birthplace Kentucky  
(City, town, or county) (State or foreign country)  
14. Maiden name Lula Walker  
15. Birthplace Tennessee  
(City, town, or county) (State or foreign country)

16. (a) Informant PT  
(b) Address Kochs Hospital

17. (a) Burial (b) Date thereof 11/15/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cem.

18. (a) Signature of funeral director Chas. Gates  
(b) Address 4107 Finney Ave.

19. (a) NOV 12 1940 (b) R. W. Polk  
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) Country \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits write "RURAL")  
(d) Street No. 3958 Finney  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 8  
year 1940 hour 6 minute 50 A. M.

21. I hereby certify that I attended the deceased from November 25, 1939, to November 8, 1940, that I last saw him alive on November 8, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis 1 1/2 yrs

Due to \_\_\_\_\_  
Due to 23

Other conditions (Include pregnancy within 5 months of death)

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

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 R. W. Polk (M. D. or other) \_\_\_\_\_  
Address Koch, Mo Date signed 11/9/40

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

**STATEMENT BY LICENSED EMBALMER**

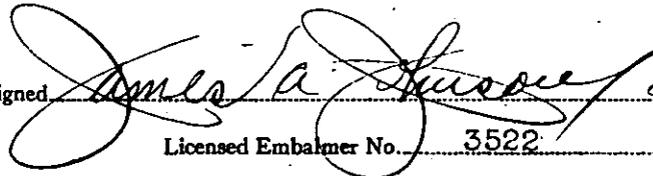
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

James A. Johnson

....., Registered Apprentice No. ....

working under my personal supervision.

Signed



Licensed Embalmer No. 3522

P. O. Address 4107 Finney Ave

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**