

FILED APR 13 1944

318

State File No. _____

Registration District No. _____

Primary Registration District No. _____

1003

Registrar's No. 2072

1. PLACE OF DEATH:

(a) County St. Louis, Missouri
 (b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Homer Phillips Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 5 days
(Specify whether
 In this community 18 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis,
(If outside city or town limits, write "RURAL")
 (d) Street No. 2601 N. Whittier
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME

Rosie Lee Anderson

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female 5. Color or race Col
 6. (a) Single, widowed, married, divorced, married
 6. (b) Name of husband or wife not known
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Mar 15 1910
(Month) (Day) (Year)

8. AGE: Years 33 Months 4 Days 12
If less than one day hr. _____ min. _____

9. Birthplace Monticello City Miss 1
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Not known
 13. Birthplace Not known
(City, town, or county) (State or foreign country)
 14. Maiden name Ellen Walt
 15. Birthplace Starkville
(City, town, or county) (State or foreign country)

16. (a) Informant Paula Eyrth
 (b) Address 1521 N. Jefferson
 17. (a) Burial (b) Date thereof 4-1-44
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director J. F. Medel
 (b) Address 2425 Glasgow
 19. (a) APR 1 1944 (b) J. F. Medel
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 27,
 year 1944 hour 9 minute 45 A. M.
 21. I hereby certify that I attended the deceased from March 22,
 1944 to March 27, 1944;
 that I last saw h. or. alive on March 27, 1944;
 and that death occurred on the date and hour stated above.

Immediate cause of death Bilateral Pyelonephritis
non calculous

Duration

Indef.

Due to _____

Due to 1932

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 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 0

23. Signature J. E. Smith (M. D. or other) _____
 Address 2601 Whittier Date signed 3/29/44

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *A. J. Richards*

Licensed Embalmer No. *2928*

P. O. Address *225 Blaney*

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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. April
Registrar's No. 3072

Registration District No. 318

Primary Registration District No. 1003

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..... (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Mo (b) County.....
(c) City or town..... St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. (1425 Biddle) (25)
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Rosie Lee Anderson

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

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... (Year)

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years 33 Months 4 Days 2 unless than one day..... min.

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

10. Usual occupation Steward

11. Industry or business.....

MOTHER FATHER

12. Name.....

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..... (b) Address.....

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

18. (a) Signature of funeral director..... (b) Address.....
19. (a) APR 18 1944 (Date received local registrar) J. F. Bredel (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March Day 27 year 1944 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 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)

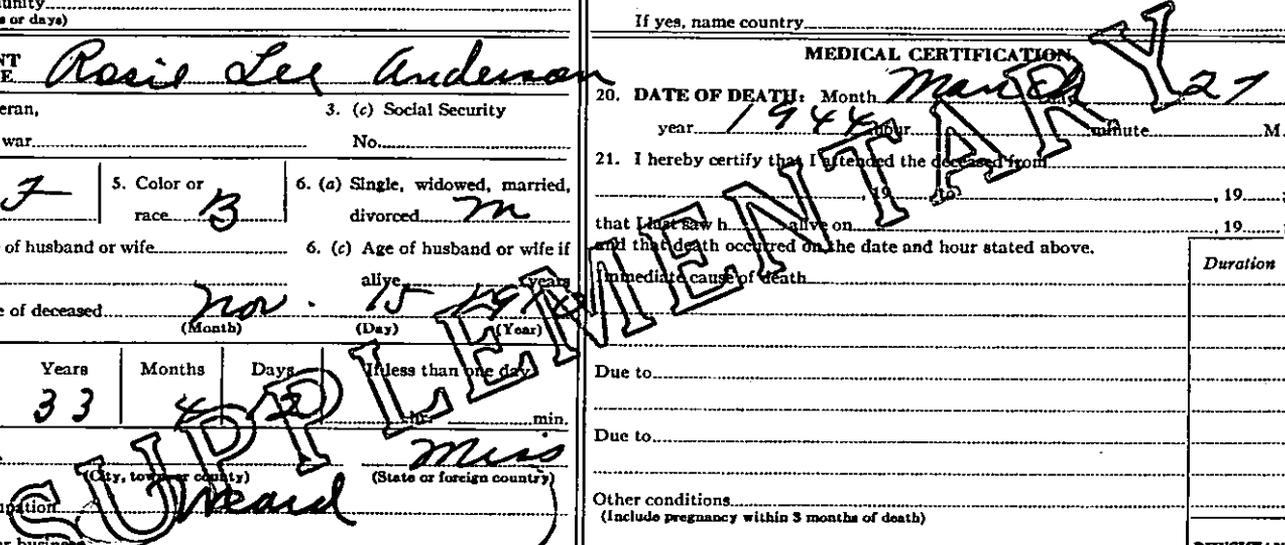
Major findings:
Of operations.....

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

23. Signature..... (M. D. or other)
Address..... Date signed.....

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



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