

FILED NOV 30 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36515

State File No.

9826

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Masonic Home of Missouri
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 mo. 3 wks
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Matthew D. Vosburgh

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced. w
6. (b) Name of husband or wife Gertrude Barr 6. (c) Age of husband or wife if alive. 1862 years
7. Birth date of deceased Nov. 14 (Month) (Day) (Year)

8. AGE: Years 82 Months 0 Days 4 If less than one day hr. min.

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

10. Usual occupation Doctor of Medicine

11. Industry or business

12. Name Oscar Vosburgh
13. Birthplace Titusville, Pa. (City, town, or county) (State or foreign country)
14. Maiden name Caroline Heale
15. Birthplace Titusville, Pa. (City, town, or county) (State or foreign country)

16. (a) Informant Iva Israel
(b) Address 5351 Delmar
17. (a) Berzil (Burial, cremation, or removal) (b) Date thereof 11-20-44 (Month) (Day) (Year)
(c) Place: burial or cremation Mt Lebanon Cem.

18. (a) Signature of funeral director Howard P. Rowland
(b) Address 4355 Washington
19. (a) NOV 20 1944 (Date received local registrar) J. B. Bredeek (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5351 Delmar Blvd.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) no
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 17
year 1944 hour 10 minute 45 AM.
21. I hereby certify that I attended the deceased from September 30, 1944, to November 17, 1944;
that I last saw him alive on November 17, 1944,
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Myocarditis Duration 2 days
Due to Chronic Valvular heart disease 6 mos.

Other conditions (Include pregnancy within 3 months of death) 92a
Major findings: Of operations 92a
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) (c) Means of injury
23. Signature Delon Cameron (M. D. or other) Address St. Louis Date signed 11-17-44

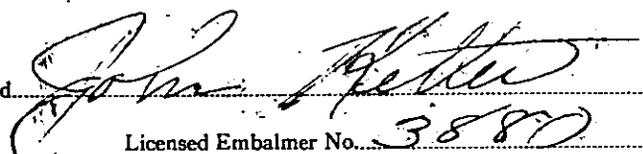
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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. 3880

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, fact should be so stated above.