

FILED APR 11 1945

Registration District No. 377

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10687

Primary Registration District No. 2076 3069

Registrar's No. 255

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Richmond Hts.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Mary's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 30 years
(Specify whether years, months or days)

In this community 30 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Max Rosenberger

3. (b) If veteran, name war no

3. (c) Social Security No. NO

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

6. (b) Name of husband or wife Pauline Pollak Rosenberger 6. (c) Age of husband or wife if alive 1892 years

7. Birth date of deceased May 13, 1892
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
52	10	9	hr. min.

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

10. Usual occupation cobbler

11. Industry or business

12. Name Samson Rosenberger

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

14. Maiden name Rachel Klein

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

16. (a) Informant Mrs. Pauline Rosenberger

(b) Address 4618 Caseyville E. St. Louis

17. (a) burial (b) Date thereof 3/23/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bnai Amoona

18. (a) Signature of funeral director Berger Memorial

(b) Address 4715 McPherson ave,

19. (a) MAR 24 1945 (b) E. G. Conway
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County St. Clair

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

(d) Street No. 4618 Caseyville
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 22
year 1945 hour 9 minute A M.

21. I hereby certify that I attended the deceased from March 15
1945 to March 22 1945;
that I last saw him alive on March 22 1945
and that death occurred on the date and hour stated above.

Immediate cause of death The original general gas Right heart failure

Due to

Due to

Other conditions 932 v
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy as above

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? no (Specify type of place) (e) Means of injury

23. Signature W. B. M. Klumpp (M. D. or other) M. W.
Address 4952 Maryland Date signed Mar 23/45

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

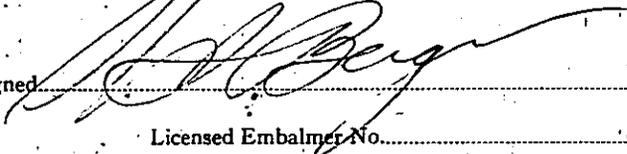
6
8
3

707

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.....

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.