

FILED JUL 26 1946
STANDARD CERTIFICATE OF DEATH
1003

Registration District No. _____ Primary Registration District No. _____

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:
Little Sisters of Poor. ⁵
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 Years.
(Specify whether years, months or days)

In this community 40 Years.

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. 3225 N. Florissant Av
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Katherine E. Rose

3. (b) If veteran, name war None

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month July day 16 year 1946 hour 7 minute 20 P.M.

21. I hereby certify that I attended the deceased from 6/15, 1946, to 7/15, 1946
that I last saw her alive on 7/15, 1946
and that death occurred on the date and hour stated above.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced, Widowed

6. (b) Name of husband or wife William A. Rose

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 2, 1873
(Month) (Day) (Year)

Immediate cause of death Chs. Myocarditis Duration 20 days

Due to Diabetes Mellitus 30 days

emphyse. left leg 30 days

Due to _____

8. AGE:

Years	Months	Days	If less than one day
<u>73</u>	<u>0</u>	<u>14</u>	hr. min.

Other conditions no
(Include pregnancy within 3 months of death)

Major findings:
Of operations no

Of autopsy no

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

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

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER

12. Name Daniel Lyons

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

14. Maiden name Anna Sheridan

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

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? _____

16. (a) Informant Mrs. Lillian O'Laughlin

(b) Address 5222 Von Phul Str.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/20/46
(Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director _____

(b) Address 2117 E. Grand Blvd.

19. (a) JUL 18 1946 (Date received local registrar)
J. F. Brubaker (Registrar's signature)

While at work? _____ (Specify type of place)

Means of injury _____

23. Signature Henry P. Lyons (M. D. or other) MD

Address 508 N. Grand Blvd. Date signed 7/18/46

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

25669

02

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

Frank A. Moore

Licensed Embalmer No. 3041

P. O. Address. 2117 E. Grand

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.