

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. **32155**
Registrar's No. **8358**

FILED OCT 6 1946
Registration District No. **318**

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(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:
St. Louis City Hospital - Max C. Starkloff
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME **ANNA ROSBERG**

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

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **M**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **April 15 1882**
(Month) (Day) (Year)

8. AGE: Years **64** Months **5** Days **11** If less than one day _____ hr. _____ min.

9. Birthplace **Ireland** (City, town, or county) (State or foreign country) **4**

10. Usual occupation **Housewife**

11. Industry or business **I**

12. Name **DURKIN**

13. Birthplace **Ireland** (City, town, or county) (State or foreign country) **4**

14. Maiden name **UNKNOWN**

15. Birthplace **"** (City, town, or county) (State or foreign country) **4**

16. (a) Informant **GUS ROSBERG**

(b) Address **5015 NO. KINGSHIGHWAY**

17. (a) **BURIAL** (Burial, cremation, or removal) (b) Date thereof **9-30-46** (Month) (Day) (Year)

(c) Place: burial or cremation **BURIAL CALVARY**

18. (a) Signature of funeral director **SULLIVAN BROS**

(b) Address **2849 NO. EUCLID**

19. (a) **SEP 29 1946** (Date received local registrar) **J. F. Brakeck** (Registrar's signature)

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. **5015 NO. Kingshighway Memorial** (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **26th**
year **1946** hour **8:45** minute **P** M.

21. I hereby certify that I attended the deceased from **8/23/46** 19 **Sept. 26th** 19 **46**
to **Sept. 26th** 19 **46**
that I last saw **her** alive on **Sept. 26th** 19 **46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of uterus with metastases**

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) _____
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? **0**

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

23. Signature **W. D. Lafayette** (M. D. or other) **W. D.**

Address **1518 Lafayette** Date signed **9/27/46**

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 *Robert L. Buskema*

Licensed Embalmer No. *3553*

P. O. Address.....

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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *Oct*

Registration District No. *318*

Primary Registration District No. *1003*

Registrar's No. *8358*

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:
(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

3. (a) PRINT FULL NAME

Anna Rosberg

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

4. Sex *F* 5. Color or race *W* 6. (a) Single, widowed, married, divorced, ~~separated~~ *Married*

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

7. Birth date of deceased: *April 15 1888*
(Month) (Day) (Year)

8. AGE: Years *64* Months _____ Days _____ If less than one day: _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) *J. F. Bredecki*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Oct* Year *1946* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

Due to _____

Due to _____

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 _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

32155