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3906

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED NOV 19 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 38139
Registration District No. 318
Primary Registration District No. 1003
Registrar's No. 9627

1. PLACE OF DEATH:
(a) County
(b) City or town St Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mo Baptist Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 wks. (Specify whether years, months or days)
In this community about 10 yrs

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. 5314 St Louis Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Mary Sesh Rosen
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 widd
6. (b) Name of husband or wife Samuel Rosen
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased Feb 15 1857 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
91	10	20	hr. min.

9. Birthplace (City, town, or county) Poland (State or foreign country) 4
10. Usual occupation at home
11. Industry or business
FATHER
12. Name Sol Lipson (Lipson) 4
13. Birthplace (City, town, or county) Poland (State or foreign country) 1
MOTHER
14. Maiden name Unknown 4
15. Birthplace (City, town, or county) Unknown (State or foreign country) 1
16. (a) Informant Mrs R P Jones
(b) Address 5314 St Louis
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/48 (Month) (Day) (Year)
(c) Place: burial or cremation Mt Sinai
18. (a) Signature of funeral director Mayer
(b) Address 4312 Lindell
19. (a) NOV 5 1948 (Date received local registrar) (b) J. B. Lasater (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 4 year 1948 hour 5 minute 20 A.M.
21. I hereby certify that I attended the deceased from Mar 27, 1943 to Nov. 4, 1948 that I last saw her alive on Nov. 3 1948 and that death occurred on the date and hour stated above.

Immediate cause of death Chr Myocarditis	Duration
Due to Senility	18 yr
Due to	
Other conditions Fractured left hip (Include pregnancy within 3 months of death)	9/24/48

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) Contributory Cause. Fractured left hip
(b) Date of occurrence Sept 24, 1948
(c) Where did injury occur? 5314 St Louis Ave St Louis, Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)
While at work? (e) Means of injury Fall
23. Signature O. E. Williamson (M. D. or other)
Address 6336 Clayton Road Date signed 11/4/48

(Licensed Embalmer's Statement on Reverse Side)

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 Elton R. H. Remelius

Licensed Embalmer No. 4283

P. O. Address St. Louis, Mo.

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.