

FILED JAN 24 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. Thomas 962
State File No. _____

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>46</u>	
1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		c. LENGTH OF STAY (In this place) <u>58 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Camp Manor Apts.</u>				d. STREET ADDRESS (If rural, give location) <u>Camp Manor Apts.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>William</u> b. (Middle) <u>H.</u> c. (Last) <u>Rosenow</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 17, 1949</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 3 1861</u>	9. AGE (In years last birthday) <u>87</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>for Salesman.</u>		11. BIRTHPLACE (State or foreign country) <u>Fon du Lac Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Keelas</u>		14. NAME OF HUSBAND OR WIFE <u>Lillian Rosenow</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Lillian Rosenow Springfield, Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Myocarditis Heart Failure</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>✓</u> DUE TO (c) <u>Sonility 1/7</u> II. OTHER SIGNIFICANT CONDITIONS <u>Acute Bronchitis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Several years</u> <u>4 years</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>1/11</u> , 19 <u>49</u> , to <u>1/17</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>1/17</u> , 19 <u>49</u> , and that death occurred at <u>1:52 pm.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>A. H. Shain M.D.</u>			23b. ADDRESS <u>324 Raudens Bldg</u>		23c. DATE SIGNED <u>1/18/49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>1/19/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn</u>		24d. LOCATION (City, town, or county) (State) <u>Springfield, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>1-19-49</u>		REGISTRAR'S SIGNATURE <u>W. E. Handley M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>H. H. Lohmeyer Springfield, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

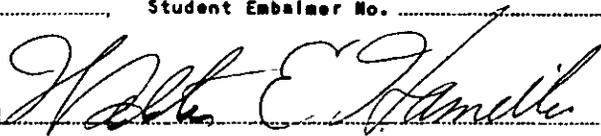
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

..... Student Embalmer No.

working under my personal supervision.

Signed



Signed

Student Embalmer

Licensed Embalmer No. 3808

P. O. Address Springfield, 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.