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FILED MAR 8 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7012

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 60 76 Registrar's No. 390

1. PLACE OF DEATH
a. COUNTY: St. Louis
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Koch (rural)
c. LENGTH OF STAY (in this place): 76 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Robert Koch Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Missouri
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
d. STREET ADDRESS (If rural, give location): 2718a Delmar

3. NAME OF DECEASED (Type or Print)
a. (First): Rosetta
b. (Middle): –
c. (Last): McCombs

4. DATE OF DEATH (Month) (Day) (Year): February 17, 1949

5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): ~~Widow (?)~~ S
8. DATE OF BIRTH: 8-6-09
9. AGE (In years last birthday): 39 — 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): Nil
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: James McCombs
13b. MOTHER'S MAIDEN NAME: Eliza Burnett
14. NAME OF HUSBAND OR WIFE: ~~London Yarbrough~~ (?)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 498-10-8963
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Robert Koch Hospital, Koch, Mo.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: ???

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

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) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 12-3-, 1948, *to* 2-17-, 1949, *that I last saw the deceased alive on* 2-17-, 19 49, *and that death occurred at* 5:30 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Bernard Friedman
23b. ADDRESS: Robert Koch Hospital
23c. DATE SIGNED: 2-18-49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Feb 22/49
24c. NAME OF CEMETERY OR CREMATORY: Greenwood Cem.
24d. LOCATION (City, town, or county) (State): St. Louis MO

DATE REC'D BY LOCAL REG.: 2-19-49
REGISTRAR'S SIGNATURE: J. V. Lemingue M.D.
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: F. L. Green 4214 Delmar

(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.

Student .....
Student Embalmer

Signed F. A. Green

Licensed Embalmer No. 2963

P. O. Address 4214 Delaval

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.