

FILED APR 23 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14478

State File No. 6026
Registrar's No. 787

BIRTH NO. _____		REG. DIST. NO. <u>348</u>		PRIMARY REG. DIST. <u>1005</u>		State File No. 6026		Registrar's No. 787											
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)														
a. COUNTY <u>ST. LOUIS COUNTY</u>					a. STATE <u>Missouri</u> b. COUNTY <u>---</u>														
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis (14) Mo.</u>				c. LENGTH OF STAY (In this place) <u>2yr; 9mos.</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Missouri</u>				17										
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. VINCENT'S SANITARIUM</u>					d. STREET ADDRESS (If rural, give location) <u>4525 Lindell</u>					9									
3. NAME OF DECEASED (Type or Print)			a. (First)			b. (Middle)			c. (Last)			4. DATE OF DEATH (Month) (Day) (Year)							
<u>ROSENFELD, Florence</u>												<u>3-31-49</u>							
5. SEX		6. COLOR OR RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)			8. DATE OF BIRTH			9. AGE (In years last birthday)		10. UNDER 1 YEAR		11. UNDER 1 HR.					
<u>Female</u>		<u>White</u>		<u>Married</u>			<u>3-7-76</u>			<u>73</u>		<u>24</u>		<u>Hours</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?							
<u>Housewife</u>				<u>---</u>				<u>Owensboro, Kentucky</u>				<u>United States</u>							
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE											
<u>Philip Rothchild</u>				<u>Betty Weil</u>				<u>Arthur Rosenfeld (husb.)</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT'S SIGNATURE OR NAME				ADDRESS							
<u>No</u>				<u>---</u>				<u>Arthur Rosenfeld</u>				<u>- 4525 Lindell</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				MEDICAL CERTIFICATION								INTERVAL BETWEEN ONSET AND DEATH							
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) <u>Cerebral Hemorrhage 331X</u>								<u>5 days</u>							
				ANTECEDENT CAUSES								DUE TO (b) <u>Cerebral arteriosclerosis</u>				<u>not known</u>			
				Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.								DUE TO (c) <u>Generalized arteriosclerosis</u>							
				II. OTHER SIGNIFICANT CONDITIONS								<u>" "</u>							
				Conditions contributing to the death but not related to the disease or condition causing death. <u>Sent. psychoses; simple diverticulosis 4 yrs</u>								<u>" "</u>							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION								20. AUTOPSY?							
<u>NO OPERATION INDICATED</u>				<u>61</u>								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT (Specify) SUICIDE HOMICIDE NATURAL CAUSES				21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)											
<u>No injury</u>				<u>No injury</u>				<u>St. Louis (14) Mo.</u>											
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)				21e. INJURY OCCURRED WHILE AT WORK				21f. HOW DID INJURY OCCUR?											
<u>No injury</u>				<input type="checkbox"/> NOT WHILE AT WORK				<u>---</u>											
22. I hereby certify that I attended the deceased from <u>6-10-46</u> , 19 <u>---</u> , to <u>3-31-49</u> , 19 <u>---</u> , that I last saw the deceased alive on <u>3-31-49</u> , 19 <u>---</u> , and that death occurred at <u>9:40 A.</u> m., from the causes and on the date stated above.																			
23a. SIGNATURE (Degree or title)						23b. ADDRESS						23c. DATE SIGNED							
<u>J. Lowry Brown</u>						<u>ST. VINCENT'S SANITARIUM</u>						<u>3-31-49</u>							
<u>7300 St. Chas. Rk. Rd., St. Louis, Mo.</u>																			
24a. BURIAL, CREMATION, REMOVAL (Specify)				24b. DATE				24c. NAME OF CEMETERY OR CREMATORY				24d. LOCATION (City, town, or county) (State)							
<u>Removal</u>				<u>3/31/49</u>				<u>Owensboro, Kentucky</u>											
DATE REC'D BY LOCAL REG.				REGISTRAR'S SIGNATURE				25. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS							
<u>MAR 31 1949</u>				<u>[Signature]</u>				<u>[Signature]</u>				<u>5216 Delmar</u>							

(Licensed Embalmer's Statement on Reverse Side)

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

S. No. 300
v. 10-4896
Kellison
0

6761 L-T-N-117

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.....
Student Embalmer

Signed.....

John Keller
Licensed Embalmer No. 3880
P. O. Address.....

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.