

FILED JUL 31 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24676**
Registrar's No. **6399**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 229 2529 Maiden Lane	
d. FULL NAME OF HOSPITAL OR INSTITUTION Christian Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Rose b. (Middle) M. c. (Last) Dannowitz			4. DATE OF DEATH (Month) (Day) (Year) July 25 1950		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH October 3 1900	9. AGE (In years last birthday) 49	IF UNDER 1 YEAR Months 9 Days 22
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brim Master		10b. KIND OF BUSINESS OR INDUSTRY Garodine Hat Co		11. BIRTHPLACE (State or foreign country) Belle Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME John Branson		13b. MOTHER'S MAIDEN NAME Elizabeth Branson		14. NAME OF HUSBAND OR WIFE Hugo Dannowitz	
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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.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Hugo Dannowitz 2529 Maiden Lane			
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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		INTERVAL BETWEEN ONSET AND DEATH 1 da
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Myocarditis, Chronic 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 <input type="checkbox"/> NO <input type="checkbox"/>
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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? H22

22. I hereby certify that I attended the deceased from **2/28, 1930**, to **7-25, 1950**, that I last saw the deceased alive on **7/25, 1950**, and that death occurred at **12:35 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE J. B. Faseler	(Degree or title) M.D.	23b. ADDRESS 2505 N. Thompson	23c. DATE SIGNED 7-26-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial (1)	24b. DATE July 28 1950	24c. NAME OF CEMETERY OR CREMATORY Lake Charles Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Co Mo
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DATE REC'D BY LOCAL REG. JUL 26 1950	REGISTRAR'S SIGNATURE J. B. Faseler	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Calvin F Futz 4828 Nat Bridge Blvd
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(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 Ralph C. Zindler

Licensed Embalmer No. 4275

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.