

FILED DEC 20 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43294

State File No.

318

1003

9139

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS, MISSOURI		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Ladue	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) #5 Prado Drive	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL			

3. NAME OF DECEASED (Type or Print) a. (First) DORA	b. (Middle)	c. (Last) ROSEN	4. DATE OF DEATH (Month) (Day) (Year) 10 16 51
--	-------------	-----------------	---

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Unknown	9. AGE (In years last birthday) Abt. 38	IF UNDER 1 YEAR: Months Days	IF UNDER 4 WKS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Russia 6		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Jacob Rosen
----------------------------	-----------------------------------	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Abe Pollock-#5 Prado Drive
---	-------------------------	--

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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ANEMIA		APPOX. 2MONTH
	ANTECEDENT CAUSES DUE TO (b) CHRONIC LYMPHATIC LEUKEMIA Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c)		4 YEARS
II. OTHER SIGNIFICANT CONDITIONS HEMOLYTIC (ACQUIRED) ANEMIA THROMBOCYTOPENIC PURPURA		INDETERMINATE	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" 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? 20 H.O
---	--	-----------------------------------

22. I hereby certify that I attended the deceased from 10/15, 1951, to 10/16, 1951, that I last saw the deceased alive on 10/16/ 1951, and that death occurred at 12:20P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) C. D. Vermillion M.D.	23b. ADDRESS BARNES HOSPITAL	23c. DATE SIGNED 10/16/51
--	------------------------------	---------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 10/17/51	24c. NAME OF CEMETERY OR CREMATORY Mt. Sinai Cemetery	24d. LOCATION (City, town, or county) (State) Omaha, Nebraska
---	--------------------	---	---

DATE REC'D BY LOCAL REGS OCT 17 1951	REGISTRAR'S SIGNATURE J. Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Herman Linderhof, 52-14 Dehaas
--------------------------------------	--	---

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

i

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..... *Peter B. DeLeon*

Licensed Embalmer No. *3691*

P. O. Address *Rockledge*

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.