

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43540

No. 300
10.48

FILED JAN 10 1953

State File No. 11395

318

1003

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 <u>Mo.</u> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		c. LENGTH OF STAY (In this place) <u>1 day</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		<u>2059</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Lutheran Hosp.</u>				d. STREET ADDRESS (If rural, give location) <u>5791 McPherson</u>					
3. NAME OF DECEASED a. (First) <u>ROSE</u> b. (Middle) _____ c. (Last) <u>JOSEPH</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 9, 1952</u>						
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Marr.</u>		8. DATE OF BIRTH <u>about 1883</u>		9. AGE (In years, months, days, hours, minutes) <u>69</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Great Britain</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>Ely Joseph</u>			13b. MOTHER'S MAIDEN NAME <u>Elizabeth Waldman</u>		14. NAME OF HUSBAND OR WIFE _____				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Sophie Joseph 5791 McPherson</u>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>One does not mean the cause of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <u>17 hrs</u>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u>					
				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 checked="" 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) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>331X</u>					
22. I hereby certify that I attended the deceased from <u>July 1950</u> to <u>Dec 9, 1952</u> that I last saw the deceased alive on <u>Nov 9, 1952</u> and that death occurred at <u>5:12</u> m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Edward W. Gubinski M.D.</u>				23b. ADDRESS <u>3701 Grandel St</u>		23c. DATE SIGNED <u>12/11/52</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>12/11/52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>B'nai Amoona</u>		24d. LOCATION (City, town, or county) (State) <u>University City Mo.</u>			
DATE REC'D BY LOCAL OFFICE <u>DEC 10 1952</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Berger Memorial 4715 McPherson</u>				

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 *James P. Quiring*
Licensed Embalmer No. 4229

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.

THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF VITAL STATISTICS

State File No. 43540

Local Registrar's No. 11395

Missouri
City of St. Louis } ss.
~~XXXXX~~

AFFIDAVIT FOR CORRECTION OF A RECORD

On this 15th day of December, 1952, before me appears Mr. Marvin A. Stein, who, upon his oath, states that the original record of ~~birth~~ death

for Rose Joseph, ~~born~~ ^{died} December 9, 1952 in the State of Missouri, and which was filed at St. Louis on Dec. 10, 1952, should be corrected as follows:

Item No. 8 should read unknown About 1883

Instead of April 3, 1875

Item No. 9 should read About 69

Instead of 77

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

The above is true to the best of my knowledge, information and belief

(SEAL)

Affiant

Marvin A. Stein
Bernard Relationship
Fun D.

Present Address.

Subscribed and sworn to before me this 15th day of December, 1952

My Commission expires June 8, 1954 Notary Public.

Affidavits containing erasures will not be accepted; draw one line through error and write above it.

0622