

No. 300
10-48

FILED JAN 8 - 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 43961

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 531 Registrar's No. 3347

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN University City Mo.
c. LENGTH OF STAY (In this place) 26 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION 732 West Gate

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo. b. COUNTY St. Louis
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN University City
d. STREET ADDRESS (If rural, give location) 732 West Gate

3. NAME OF DECEASED
a. (First) LAURA b. (Middle) JULIUS c. (Last) ROSEN
(Type or Print)

4. DATE OF DEATH (Month) (Day) (Year)
12 27 1952

5. SEX female
6. COLOR OR RACE W.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH June 15, 1870

9. AGE (In years last birthday) 82
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) at home

10b. KIND OF BUSINESS OR INDUSTRY Housewife

11. BIRTHPLACE (State or foreign country) Illinois

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Philip Julius

13b. MOTHER'S MAIDEN NAME Charlotte (?)

14. NAME OF HUSBAND OR WIFE Joseph Rosen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT'S SIGNATURE OR NAME ADDRESS
Otto W. Julius 625 S. Skinker

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
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Embolia cerebral -
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause, (a) stating the underlying cause last.
DUE TO (b) Auricular Fibrillation
DUE TO (c) Myocarditis (chronic)
II. OTHER SIGNIFICANT CONDITIONS -
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH
1 Day
3 days
1 year

19a. DATE OF OPERATION none

19b. MAJOR FINDINGS OF OPERATION none

20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) none

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
none

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) none m.

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? 4222

22. I hereby certify that I attended the deceased from Dec 20, 1952, to Dec 27, 1952, that I last saw the deceased alive on Dec 27, 1952, and that death occurred at 6 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Scott Hever, M.D.

23b. ADDRESS 634 N. Grand

23c. DATE SIGNED Dec 29-52

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 12/29/52

24c. NAME OF CEMETERY OR CREMATORY Mt. Olive (Jewish)

24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.

DATE REC'D BY LOCAL REG. 12-30-52

REGISTRAR'S SIGNATURE Hubert R. Danke - M.D.

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
Mayer 4356 Lindell

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 Me

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed Elton St. Penelias

Licensed Embalmer No. 4283

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.