

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

42764

FILED DEC 16 1954

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10531**

1. PLACE OF DEATH a. COUNTY <u>City</u>		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) OR TOWN <u>City</u>	c. LENGTH OF STAY (in this place) <u>2-yrs.</u>	c. CITY OR TOWN <u>City</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis Chronic Hosp.</u>		e. STREET ADDRESS (If rural, give location) <u>13 5800 Arsenal St.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Katherine</u> b. (Middle) _____ c. (Last) <u>Rose</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>11-18-1954.</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 31, 1876</u>		9. AGE (in years last birthday) <u>78</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>6</u>	IF UNDER 24 HRS. Hours _____ Min. _____
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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>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>James Coad</u>		13b. MOTHER'S MAIDEN NAME <u>Ann Whalen</u>		14. NAME OF HUSBAND OR WIFE <u>Mr. Shepperd Rose</u>	
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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) <u>no</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Shepperd Rose, 10145 Earl Dr.</u>			
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18. CAUSE OF DEATH- Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Generalized arteriosclerosis</u>		DUPLICATE OF (a) _____			
* This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES			
		DUE TO (b) _____			
		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"/>	
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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) <u>4500</u>	
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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? _____	
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22. I hereby certify that I attended the deceased from 8-27, 1952, to 11-18, 1954, that I last saw the deceased alive on 11-18, 1954, and that death occurred at 11:05pm., from the causes and on the date stated above.

22a. SIGNATURE (Degree or title) <u>Palusa Romain Bowlish M.D.</u>		22b. ADDRESS <u>5800 Arsenal St.</u>		22c. DATE SIGNED <u>11-19-54</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Nov. 22, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>		
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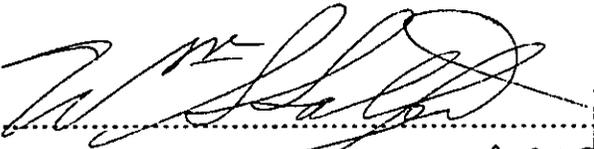
DATE REC'D BY LOCAL REGISTRY <u>NOV 19 1954</u>	REGISTRAR'S SIGNATURE <u>Carl Smith</u>		FUNERAL DIRECTOR'S SIGNATURE <u>J. Donnelly</u>		ADDRESS <u>3840 Lindell Blvd.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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.....  
Signature of Student Embalmer

Signed.....  


Licensed Embalmer No. 469

P. O. Address 3840

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.