

FILED JAN 18 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 1767  
Registrar's No. 3048

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 209 PRIMARY REG. DIST. NO. 3048

1. PLACE OF DEATH a. COUNTY <u>MARION</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>MONROE</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>HANNIBAL</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>STELIZABETH HOSPITAL</u>		d. STREET ADDRESS (If rural, give location) <u>STOUTSVILLE</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>EMMA</u> b. (Middle) _____ c. (Last) <u>ROSENSTENGEL</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>JANUARY 1 1955</u>	
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>NOVEMBER 17, 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE KEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	9. AGE (In years last birthday) <u>77</u> IF UNDER 1 YEAR Months <u>1</u> Days <u>14</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
11. BIRTHPLACE (State or foreign country) <u>Monroe County, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>WILLIAM ORE</u>		13b. MOTHER'S MAIDEN NAME <u>RACHEL LAWRENCE</u>	
14. NAME OF HUSBAND OR WIFE <u>CLARENCE ROSENSTENGEL</u>		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>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Clarence Rosenstengel</u> ADDRESS <u>Stoutsville Mo</u>	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchial Pneumonia</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) <u>Intratrochenteric fracture left hip</u> DUE TO (c) <u>Chronic myocarditis, arteriosclerotic</u> II. OTHER SIGNIFICANT CONDITIONS in type; hypertension; diabetes mellitus Conditions contributing to the death but not related to the disease or condition causing death.	
INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>		10 days	
19a. DATE OF OPERATION <u>12-24-54</u>		19b. MAJOR FINDINGS OF OPERATION: <u>Fracture, intratrochenteric, left hip</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT (Specify) <u>Accident</u> 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>none</u> 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Stoutsville Monroe MO</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Dec 22 '54' 5PM</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 21f. HOW DID INJURY OCCUR? <u>fell in home</u>	
22. I hereby certify that I attended the deceased from <u>12-22</u> , 19 <u>54</u> , to <u>1-1</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>1-1</u> , 19 <u>55</u> , and that death occurred at <u>4:18 Pm.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>[Signature]</u> M.D., F.A.C.S.		23b. ADDRESS <u>100 N. 6th, Hannibal, Mo.</u>	
23c. DATE SIGNED <u>1-3-55</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 24b. DATE <u>1-3-1954</u> 24c. NAME OF CEMETERY OR CREMATORY <u>St Andrew Cemetery</u> 24d. LOCATION (City, town, or county) (State) <u>STOUTSVILLE Missouri</u>	
DATE REC'D BY LOCAL REG. <u>Jan 3-1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u> 25. FUNERAL DIRECTOR'S SIGNATURE <u>WILSON &amp; SONS, Monroe City Mo.</u> ADDRESS <u>[Address]</u>	

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

RECEIVED JAN 17 1955  
MARION CO. HEALTH DEPT.  
DATE FILED JAN 17 1955

**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 Leslie L. Wilson

Licensed Embalmer No. ....

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.