

FILED APR 27 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **13832**
Registrar's No. **2991****318****1003**

No. 300

10. 48

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

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 Co.			
b. CITY (If outside corporate limits, write RURAL and give town OR TOWN St. Louis)		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN Wellston 431 /		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION DePaul Hospital				STREET ADDRESS (If rural, give location) 1113 Delaware Ave.,			
3. NAME OF DECEASED (Type or Print) a. (First) SIDNEY		b. (Middle) HALL		c. (Last) ROSEBROUGH		4. DATE OF DEATH (Month) (Day) (Year) April 4, 1955	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 7, 1894		9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months _____	IF UNDER 24 HRS. Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) Tool crib attendant		10b. KIND OF BUSINESS OR INDUSTRY Wagner E. Co.		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? US	
13a. FATHER'S NAME Charles Rosebrough		13b. MOTHER'S MAIDEN NAME Ida Hageman		14. NAME OF HUSBAND OR WIFE Agnes Rosebrough			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 494-09-2908		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Agnes Rosebrough 1113 Delaware Av			
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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction Coronary Sclerosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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.					INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
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? 4201			
22. I hereby certify that I attended the deceased from 5-3 , 19 54 , to 4-1 , 19 55 , that I last saw the deceased alive on 4-1 , 19 55 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.							
23a. SIGNATURE J. Hayden M.D. (Degree or title) _____				23b. ADDRESS 730 Hodiamont		23c. DATE SIGNED 4/2/55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE April 4, 1955	24c. NAME OF CEMETERY OR CREMATORY Calvary Cem.,		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		
DATE REC'D BY LOCAL REG. APR 4 1955		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Jos. W. Clark 1125 Hodiamont Ave.,			

(Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed *John J. Haines*

Licensed Embalmer No. *410*

P. O. Address *H. Davis*

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.