

FILED APR 28 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13833

State File No.

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 3289	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis, Mo.)		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN St. Louis,		d. Is Residence within limits of city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4406 McPherson Ave.				STREET ADDRESS (If rural, give location) 4406 McPherson Ave.			
3. NAME OF DECEASED (Type or Print) a. (First) Herman		b. (Middle) J.		c. (Last) Rosenfeld		4. DATE OF DEATH (Month) (Day) (Year) April 12, 1955	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married		8. DATE OF BIRTH Aug. 14, 1897	
9. AGE (In years last birthday) 57		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 2 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY Doctor Medicine		11. BIRTHPLACE (City and State or Foreign Country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Adolph Rosenfeld		13b. MOTHER'S MAIDEN NAME Johannah Stern		14. NAME OF HUSBAND OR WIFE Never Married			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give year or dates of service) Nil.		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Johannah Jacobi, 637 Geoffrey Lane			
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.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) arteriosclerotic heart dis. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized arteriosclerosis DUE TO (c) Diabetes II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Amputation R. leg 1953				MEDICAL CERTIFICATION University City, Mo. INTERVAL BETWEEN ONSET AND DEATH 2 wks. 8 yrs. 20 yrs.	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input 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? 260X			
22. I hereby certify that I attended the deceased from July 1, 1953 , to Apr. 12, 1955 , that I last saw the deceased alive on Apr. 11, 1955 , and that death occurred at 6:20 A. m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Herman Rosenfeld MD				23b. ADDRESS 3903 Olive St.		23c. DATE SIGNED Apr. 12, 1955	
24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		24b. DATE 4-14-55		24c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory		24d. LOCATION (City, town, or county) (State) St. Louis, County, Mo.	
DATE REC'D BY LOCAL REG. APR 12 1955		REGISTRAR'S SIGNATURE J. Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Mayer Fun. Home, 4356 Lindell Blvd.			

WRITE PLAINLY—USING UNFADEING 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.....
Signature of Student Embalmer

Signed.....
Ray W. Wilkinson

Licensed Embalmer No. 35

P. O. Address *19 Row*

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.