

FILED JUL 7 - 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **20574**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **541** Registrar's No. **1379**

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Clayton</b>		c. CITY OR TOWN <b>Clayton</b>	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: <b>7549 Parkdale Ave.</b>		e. STREET ADDRESS (If rural, give location) <b>7549 Parkdale Ave.</b>	

3. NAME OF DECEASED (Type or Print) <b>JOSEPH JACOB ROSSEN</b>			4. DATE OF DEATH <b>JUNE 17, 1955</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	
8. DATE OF BIRTH <b>Oct. 1, 1896</b>		9. AGE (In years last birthday) <b>58</b>		10. <input type="checkbox"/> UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 2 YEARS <input type="checkbox"/> 3 YEARS <input type="checkbox"/> 4 YEARS <input type="checkbox"/> 5 YEARS <input type="checkbox"/> 6 YEARS <input type="checkbox"/> 7 YEARS <input type="checkbox"/> 8 YEARS <input type="checkbox"/> 9 YEARS <input type="checkbox"/> 10 YEARS <input type="checkbox"/> 11 YEARS <input type="checkbox"/> 12 YEARS <input type="checkbox"/> 13 YEARS <input type="checkbox"/> 14 YEARS <input type="checkbox"/> 15 YEARS <input type="checkbox"/> 16 YEARS <input type="checkbox"/> 17 YEARS <input type="checkbox"/> 18 YEARS <input type="checkbox"/> 19 YEARS <input type="checkbox"/> 20 YEARS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retail Store Furniture</b>			11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis Missouri</b>		
10b. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		

13a. FATHER'S NAME <b>Harry Rossen</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Frieda B. Rossen</b>	
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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) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Frieda B. Rossen 7549 Parkdale</b>	
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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) <b>Cerebral Vascular Thrombosis</b>		DUPLICATE TO (b) <b>Hypertensive Cardiovascular Disease</b>			<b>9 years</b>	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		DUPLICATE TO (c)			<b>20 years</b>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Arteriosclerosis, general</b>					<b>years</b>	

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) <b>443X</b>	
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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 **Sept. 25, 1946**, to **June 17, 1955**, that I last saw the deceased alive on **June 17, 1955**, and that death occurred at **8:35 a. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Narold Scheff M.D.</b>		23b. ADDRESS <b>457 N. Kingshighway</b>		23c. DATE SIGNED <b>6/17/55</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>6/19/55</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Chesed Shel Emeth Cem.</b>	
				24d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Missouri</b>	

DATE REC'D BY LOCAL REG. <b>6/12/55</b>		REGISTRAR'S SIGNATURE <b>Herbert C. Donke MD</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Herman Rindskopf Inc. 5216 Delmar Bl.</b>	
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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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *John Ketter*.....

Licensed Embalmer No. *388*.....

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