

FILED NOV 15 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 34886

9188

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** 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 _____	
b. CITY (If outside corporate limits, write RURAL, and give township) OR TOWN ST. LOUIS Mo	c. LENGTH OF STAY (In this place) _____	c. CITY OR TOWN ST. LOUIS	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 ST. ANTHONY HOSPITAL		e. STREET ADDRESS (If rural, give location) 916 HICKORY 2279	

3. NAME OF DECEASED (Type or Print) a. (First) ROSIE b. (Middle) - c. (Last) JOSEPH	4. DATE OF DEATH (Month) (Day) (Year) OCT. 20 1955
---	--

5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH FEB. 2, 1902	9. AGE (In years last birthday) 53	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
----------------------	-------------------------------	---	--------------------------------------	---	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE	10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (City and State or Foreign Country) MISSOURI	12. CITIZEN OF WHAT COUNTRY? U.S.A
---	--	--	---

13a. FATHER'S NAME JOHN SIMON	13b. MOTHER'S MAIDEN NAME ELIZABETH THOMAS	14. NAME OF HUSBAND OR WIFE PETER JOSEPH
--------------------------------------	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME PETER JOSEPH ADDRESS 916 HICKORY
--	-------------------------------------	--

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 5 years 10 years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Sudden Vasculor Remy Disease with aneurysm		
	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. Diabetes mellitus			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) 442x
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
--	--	----------------------------------

22. I hereby certify that I attended the deceased from **James**, **1955**, to **Oct 20, 1955**, that I last saw the deceased alive on **Oct 20, 1955**, and that death occurred at **11:30 a.m.**, from the causes and on the date stated above.

22a. SIGNATURE James Hayden (Degree or title) _____	22b. ADDRESS 3201 309th St. St. Louis Mo	22c. DATE SIGNED 10-21-55
--	---	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE OCT 24 1955	24c. NAME OF CEMETERY OR CREMATORY RESURRECTION	24d. LOCATION (City, town, or county) (State) ST. LOUIS Mo
--	------------------------------	--	---

DATE REC'D BY LOCAL REG. OCT 21 1955	REGISTRAR'S SIGNATURE J. Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Thomas Kutas 2906 Prairie ADDRESS _____
---	---	---

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

Dr 1-14/13
1-5 AM.

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 *Leo J. Rudde*.....
Licensed Embalmer No. *390*.....
P. O. Address *St. Louis*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.