

FILED APR 2 - 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10977

State File No.

BIRTH NO.

REG. DIST. NO.

318

PRIMARY REG. DIST. NO.

1003

Registrar's No.

2943

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, MISSOURI township)		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 checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL #1.				e. STREET ADDRESS (If rural, give location) 1106 Victor					
3. NAME OF DECEASED (Type or Print) a. (First) ROSE b. (Middle) KLAGES c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) MARCH 21, 1956						
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 10-27-1894		9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Mins.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Anna Leimonstoll		14. NAME OF HUSBAND OR WIFE Deceased					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Bernice Schodrowski, 10119 Dwight					
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral Arteriosclerosis</u> 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 <u>Swick</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 331X				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)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		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 <u>2-29</u> , 19 <u>56</u> , to <u>3-21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-21</u> , 19 <u>56</u> , and that death occurred at <u>6:00 A.M.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Frede Mortensen M.D.</u>				23b. ADDRESS 1515 LAFAYETTE AVE		23c. DATE SIGNED 3-21-56.			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3-23-1956	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cem.		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri				
DATE REC'D BY LOCAL REG. MAR 22 1956		REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS McLaughlin F.H., Inc., 2301 Lafayette					

(Licensed Embalmer's Statement on Reverse Side)

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..... *James P. Chynoweth*
Licensed Embalmer No. *43*
P. O. Address *St. Paul*

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