

Health, Welfare & Public Service

800-56

Physician, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be entered. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39749

STATE FILE NUMBER

FILED NOV 28 1956

318

1003

9979

Registration District No. Primary Registration District 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			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN ST. LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4117 SHREVE AVE.		Length of stay in lb LIFE		d. STREET ADDRESS 4117 SHREVE AVE. (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last SOPHIE L. ROSE				4. DATE OF DEATH Month Day Year OCT. 31, 1956.			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 17, 1874.	9. AGE (In years last birthday) 81	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) ST. LOUIS, MO.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME KARL OELLEFMAN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Address MR. A. CONRAD ROSE, JR. 4117 SHREVE AVE.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Failure (Cardiac failure)</i> <i>Cardiac decompensation</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Cardiac Decompensation</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 hrs</i> <i>2 years</i>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>434.3</i>				
20c. TIME OF INJURY Hour a. m. Month, Day, Year p. m.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE			
21. I attended the deceased from <i>Jan 1 - 53</i> , to <i>Oct 29 - 56</i> and last saw her alive on <i>Oct 29 - 56</i> Death occurred at <i>1:30 AM.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) E.E. King <i>E E King MD M.D.</i>				22b. ADDRESS <i>2114 E Grand</i>		22c. DATE SIGNED <i>1 Nov - 56</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE Nov. 2, 1956	23c. NAME OF CEMETERY OR CREMATORY VALHALLA CREMATORY		23d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY, MO.		
24. FUNERAL DIRECTOR ADDRESS CALVIN F. FEUTZ FUNERAL HOME, INC. 4828 NATURAL BRIDGE BLVD., ST. LOUIS, MO.				25. DATE RECD. BY LOCAL REG. NOV 1 1956		26. REGISTRAR'S SIGNATURE <i>Carl Smith MD</i>	

2:30 PM to 4:00PM
Daily except Wednesdays.

File in City

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 A. Malone*
Licensed Embalmer No. *4716*

P. O. Address *St. Louis*

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.