

No. 300  
10-48

FILED MAY 31 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **19228**  
Registrar's No. **4824**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

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. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>	c. LENGTH OF STAY (in this place) _____	c. CITY OR TOWN <b>St. Louis</b>	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 <b>St. Louis State Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>5400 Arsenal St.</b>	

3. NAME OF DECEASED (Type or Print) <b>Mary Roser</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>May 1, 1957</b>	
a. (First)	b. (Middle)	c. (Last)	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Oct. 17, 1884</b>
9. AGE (In years last birthday) <b>72</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 11 YRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>
			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>

13a. FATHER'S NAME <b>Peter Roser</b>	13b. MOTHER'S MAIDEN NAME <b>Eva</b>	14. NAME OF HUSBAND OR WIFE _____
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <b>Hospital Records</b> ADDRESS <b>5400 Arsenal St.</b>

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>Pneumonitis, mid third of both lungs</b>		<b>1 month</b>	
*This does not mean the mode of dying, such as heart failure, arteria, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES			
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			
		DUE TO (b) <b>Bilateral pleural effusion</b>			
		DUE TO (c) _____			
		II. OTHER SIGNIFICANT CONDITIONS			
		Conditions contributing to the death but not related to the disease or condition causing death. <b>Mental Deficiency</b>		<b>492+</b>	

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? <b>2</b> 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 **March 5, 19 26**, to **May 1st, 19 57**, that I last saw the deceased alive on **May 1st, 19 57**, and that death occurred at **8:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Anna Hyman</b> (Degree or title) <b>MD</b>	23b. ADDRESS <b>5400 Arsenal Street</b>	23c. DATE SIGNED <b>5-1-57</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) _____	24b. DATE <b>5-31-57</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>
		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>

DATE REC'D BY LOCAL REG. <b>MAY 23 57</b>	REGISTRAR'S SIGNATURE <b>Carl Smith</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Rowland-Aker Mortuary Service</b> ADDRESS <b>4104 Manchester Ave. St. Louis 10, Mo.</b>
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**STATEMENT BY LICENSED EMBALMER**

State of \_\_\_\_\_

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.....

Licensed Embalmer No.....

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.