

pt. Health,
, & Welfare
S. Public
alth Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4-20-51

FILED NOV 27 1957

Registration District No. 318

Primary Registration District No. 1003

STATE FILE NUMBER
11063
Registrar's No.

S. 300
ev. 1-57
All diseases in Part I must be causally related.
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
Securing the medicor certificate in the manner required by 192.140 RSMo. 1947.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>1</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MO.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>ST. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>25 ST. LOUIS CITY HOSP. #1.</u>		Length of stay in 1b <u>#1.</u>		d. STREET ADDRESS (If outside, give location) <u>1237 1038 ALLEN AVE.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HELEN</u> Middle <u></u> Last <u>ROSEN</u>				4. DATE OF DEATH Month <u>NOV.</u> Day <u>18,</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 14, 1892</u>	9. AGE (In years last birthday) <u>65</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (City and state or country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>? Hauschild</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>DECEASED</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, <u>No</u>) (If yes, give <u>No</u> dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>LEONA ROSEN, R9, LEMAY, MO</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>3314</u>						INTERVAL BETWEEN ONSET AND DEATH	
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.)				
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____							
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <u>11/17/57 5:20 A</u> to <u>11/18/57</u> and last saw her/him alive on <u>11/18/57</u> Death occurred at <u>7:05 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Joseph Drew Callahan MD</u>				22b. ADDRESS <u>1515 LAFAYETTE AVE.</u>		22c. DATE SIGNED <u>11/19/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>11-21-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>S.S. PETER & PAUL</u>		23d. LOCATION (City, town, or county) (State) <u>ST. Louis Mo</u>		
24. FUNERAL DIRECTOR ADDRESS <u>FENDLER UND. Co, 7420 Michigan</u>			25. DATE RECD. BY LOCAL REG. <u>NOV 19 57</u>		26. REGISTRAR'S SIGNATURE <u>J. Carl Smith, MD</u> <u>S.P.</u>		

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 *W. J. Peterson*

Licensed Embalmer No. *3761*

P. O. Address *7420 Michigan*

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.