

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-027390  
STATE FILE NUMBER

FILED JUL 24 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7028

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lutheran Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>3652 So. Jefferson Ave</b>	
Length of stay in lb <b>42 yrs</b>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROSE</b> Middle <b>ROSEMAN</b> Last <b>R</b>			4. DATE OF DEATH Month <b>July</b> Day <b>14</b> Year <b>1958</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 8, 1882</b>
9. AGE (In years last birthday) <b>75</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>	11. BIRTHPLACE (City and state or country) <b>Baldwin, Illinois</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Casper Nurnberger</b>		13b. MOTHER'S MAIDEN NAME <b>Barbara Baum</b>	14. NAME OF HUSBAND OR WIFE <b>Edward Roseman</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>---</b>	17. INFORMANT Address <b>W. E. Piehl, 8721 Halls Ferry Road</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of the rectum</b>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not terminal disease condition given in PART I (a) <b>Hypertensive Atherosclerosis</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>
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 _____ a.m. _____ p.m. Month, Day, Year _____			
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 Death: occurred at <b>12:10 P. M.</b> on <b>7/10/58</b> to <b>7/14/58</b> and last saw her alive on <b>7/14/58</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Chas. C. Haines M.D.</b> (Degree or title)		22b. ADDRESS <b>3015 Lafayette</b>	
22c. DATE SIGNED <b>7/15/58</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>July 16, 1958</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Concordia Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>	
24. FUNERAL DIRECTOR <b>BEIDERWIEDEN F.H. INC., 1936 St. Louis Ave</b>		25. DATE RECD. BY LOCAL REG. <b>JUL 16 58</b>	
ADDRESS		26. REGISTRAR'S SIGNATURE <b>Charles Smith mo</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Specimen container, etc., must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

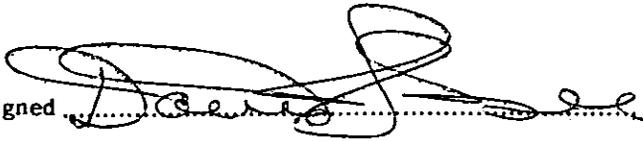
Dr. Otto Hanser  
3012 Lafayette Avenue

10-1 6-8

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  \_\_\_\_\_

Licensed Embalmer No. 457  
P. O. Address Hanser

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.