Health, Welfare Public Service

300 -57

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-007587

STATE FILE NUMBER

FILED MAR 10 1959

Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 1704

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Louis — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN St. Louis — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Jewish Hosp. — Length of stay in 1b 15 yrs.	d. STREET ADDRESS (If outside, give location) 5560 Pershing Park Manor Hotel — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First FRANK	Middle	Last ROSENBERG	4. DATE OF DEATH Month Day Year Feb. 17, 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]	8. DATE OF BIRTH Unk.
9. AGE (In years last birthday) ab. 80	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant	10b. KIND OF BUSINESS OR INDUSTRY Retail Dry Gds.	11. BIRTHPLACE (City and state or country) Poland 4	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Joseph Rosenberg	13b. MOTHER'S MAIDEN NAME Unk.	14. NAME OF HUSBAND OR WIFE -	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. Unk.	17. INFORMANT Mrs. Mollie Kauffman	Address #3 Cricklewood, Frontenac

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinoma of Colon — INTERVAL BETWEEN ONSET AND DEATH 6 months

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Acute Myocardial Infarction — 1 day

DUE TO (c) Arteriosclerotic Heart Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 153.8

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 1

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

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 [ ] NOT WHILE AT WORK [ ]

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 2/1/59, to 2/17/59 and last saw her/him alive on 2/17/59

Death occurred at 10 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Alvin S. Wenneker, M.D.	22b. ADDRESS 950 Francis	22c. DATE SIGNED 2/17/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Rem.	23b. DATE 2/19/59	23c. NAME OF CEMETERY OR CREMATORY B'nai Ammona	23d. LOCATION (City, town, or county) (State) University City, Mo.
24. FUNERAL DIRECTOR Berger memorial	ADDRESS 4715 McPherson	25. DATE RECD. BY LOCAL REG. FEB 17 '59	26. REGISTRAR'S SIGNATURE Carl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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. .....

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.