

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007875

STATE FILE NUMBER

Registration District No. 317

Primary Registration District No. 541

Registrar's No. 459

REC FEB 24 1959

300
-57

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Clayton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>University City</u> 4366
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTE <u>County Hos p.</u>		Length of stay in lb <u>DOA</u>	d. STREET ADDRESS (If outside, give location) <u>8109 Appleton</u>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>H.</u> Last <u>ROSEN</u>	4. DATE OF DEATH Month <u>Feb.</u> Day <u>15</u> Year <u>1959</u>
---	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1902</u>	9. AGE (In years last birthday) <u>56</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
-----------------------	----------------------------------	---	---	--	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Grocer</u>	11. BIRTHPLACE (City and state or country) <u>England</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
--	---	--	--

13a. FATHER'S NAME <u>Garshon Rosen</u>	13b. MOTHER'S MAIDEN NAME <u>Rebecca (unk)</u>	14. NAME OF HUSBAND OR WIFE <u>Sarah</u>
--	---	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT Address <u>Sarah Rosen 8109 Appleton</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>C coronary thrombosis - myocardial infarction - 2 weeks</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Auto. Sclerotic Heart Disease.</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>4200</u>	INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 yrs</u>
---	--

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.) <u>4200</u>
---	---

20c. TIME OF INJURY Hour _____ a.m. _____ 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 <u>University City, Mo.</u>	COUNTY _____ STATE _____
---	--	--	---	--------------------------

21. I attended the deceased from <u>5/21/58</u> P. and last saw her alive on <u>2/15/59</u> Death occurred at <u>10.00</u> P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Dr. E. Stanley M.D.</u>	22b. ADDRESS <u>3790 Washington</u>	22c. DATE SIGNED <u>2/16/59</u>
--	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2/17/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chesed Shel Emeth</u>	23d. LOCATION (City, town, or county) (State) <u>University City, Mo.</u>
--	-----------------------------	--	--

24. FUNERAL DIRECTOR <u>Berger Memorial 4715</u> ADDRESS <u>Cherson</u>	25. DATE RECD. BY LOCAL REG. <u>2-17-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy, M.D.</u>
--	--	--

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 Lawrence J. Davis
Licensed Embalmer No. 3988

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.