

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015640

STATE FILE NUMBER
3 4022

FILED MAY 11 1959

Registration District No. Primary Registration District No.

300
-57
42
I

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ill. b. COUNTY Madison	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Madison	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Hamilton Med. Center		d. STREET ADDRESS 1100 Calhoun	

3. NAME OF DECEASED (Type or print) First MOLLIE Middle Last ROSENSTROM			4. DATE OF DEATH Month Day Year April 24, 1959		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 2. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-2-1888	9. AGE (In years at birthday) 70	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Lithuania 8	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Isaac Rosenthal	13b. MOTHER'S MAIDEN NAME Unk.	14. NAME OF HUSBAND OR WIFE Louis
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Greenberg 8327 Delmar
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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>Parkinson's Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Art. Sci. & Hypertensive L-V Dis.</u>	
	DUE TO (c) <u>443 X</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <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
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21. I attended the deceased from Death occurred at <u>9:15</u> on <u>1/9/50</u> to <u>4/24/59</u> and last saw her alive on <u>4/24/59</u> m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Arthur S. Strands</u>	(Degree or title)	22b. ADDRESS <u>3720 Washington</u>	22c. DATE SIGNED <u>4/24/59</u>
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23a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) <u>Rem.</u>	23b. DATE <u>4/26/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chesed Shel Emeth</u>	23d. LOCATION (City, town, or county) (State) <u>University City, Mo.</u>
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24. FUNERAL DIRECTOR <u>Berger Memorial 4715 McPherson</u>	25. DATE RECD. BY LOCAL REG. <u>APR 24 '59</u>	26. REGISTRAR'S SIGNATURE <u>Loard Smith, M.D., C.P.</u>
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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 
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.