RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS SEP 4 1959

59–030397
STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 7768

DED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St.Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 5736 McPherson
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY
c. CITY OR TOWN: St.Louis
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 5736 McPherson
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Carrye Middle: Rosenheim Last: Frisch
4. DATE OF DEATH: Month: August Day: 19. Year: 1959
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 5/20/1883
9. AGE (last birthday): 76
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HR: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (City and state or country): Chicago, Ill.
12. CITIZEN OF WHAT COUNTRY: U.S.
13a. FATHER'S NAME: Emil Rosenheim
13b. MOTHER'S MAIDEN NAME: Caroline Fuller
14. NAME OF HUSBAND OR WIFE: Oscar
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.: None
17. INFORMANT: Mrs. Jane Bialock, 5736 McPherson Address

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): Pulmonary Embolus. — INTERVAL BETWEEN ONSET AND DEATH: instant
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Phlebothrombosis, lower extremities — indeterminate
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Hypertensive Cardiovascular Disease
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
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 1/31/41 to 8/19/59 and last saw her/him alive on 8/14/59
Death occurred at 4 P m on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: Morris Clark MD (Degree or title)
22b. ADDRESS: 3720 Washington Ave
22c. DATE SIGNED: 8/20/59

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE: 8-21-59
23c. NAME OF CEMETERY OR CREMATORY: Valhalla Crematory
23d. LOCATION (City, town, or county) (State): St.Louis Co., Mo.
24. FUNERAL DIRECTOR ADDRESS: Albert H.Hoppe, Inc., 4700 Washington Blvd.
25. DATE REC'D. BY LOCAL REG.: AUG 21 '59
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D. S.P.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co
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.