

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-003996**

**FILED VS. JAN 22 1960**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2127** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jewish Hospital</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3251 Suson Ct.</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>MARTIN</b> Middle <b>P.</b> Last <b>ROSENMEYER SR.</b>			4. DATE OF DEATH Month <b>Jan.</b> Day <b>3</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8-23-1898</b>	9. AGE (last birthday) <b>61</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civil Engineer-Marcel Boulicault Inc.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>St. Louis, Mo.</b>		11. BIRTHPLACE (City and state or country) <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Philip Rosenmeyer</b>		13b. MOTHER'S MAIDEN NAME <b>Clara Busch</b>		14. NAME OF HUSBAND OR WIFE <b>Rosemary Rosenmeyer</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes W.W.#1-W.W.#2</b>		16. SOCIAL SECURITY NO. <b>490-03-8460</b>		17. INFORMANT Address <b>Rosemary Rosenmeyer 3251 Suson Ct</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Cardiac Tamponade Hemopericardium</b>		<b>1 hr</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Dissecting Aneurism Aorta</b>	<b>4 days</b>
	DUE TO (c) <b>Arterial degeneration 45+</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	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 **1967** to **Jan 20** and last saw <sup>her</sup>him alive on **Jan 3 '60**  
Death occurred at **11:45 P.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Paul K. Webb M.D.</b>	22b. ADDRESS <b>721 Olive St. St. Louis, Mo</b>	22c. DATE SIGNED <b>1-4-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Jan. 6, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>S/S Peter &amp; Paul Cem.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Kriegshauser 4228 S. Kingshighway</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>

25. DATE RECD. BY LOCAL REG. <b>JAN 5 1960</b>	26. REGISTRAR'S SIGNATURE <b>Paul Smith M.D.</b>
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DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

**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 \_\_\_\_\_  
Signature of Student Embalmer

Signed William B White

Licensed Embalmer No. 4281

P. O. Address 2228 W. King St

**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.