

UNR DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-009271

FILED WS MAR 1 0 1966

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 617 STATE FILE NUMBER

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	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond Heights</u>		Length of stay in 1b <u>20 Days</u>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Marys Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1300 So. 14th. St</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Harriet</u> Middle <u>Brown</u> Last <u>Rosenthal</u>			4. DATE OF DEATH Month <u>February</u> Day <u>22</u> Year <u>1960</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7/13/1886</u>	9. AGE (last birthday) <u>73</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and state or county) <u>Grafton, Ill</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Lewis Brown</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Godfrey</u>		14. NAME OF HUSBAND OR WIFE <u>Harry Rosenthal</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>None</u>		17. INFORMANT <u>Dr. T.W. Parker 7298 Greenway</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>generalized metastasis from melanoma</u> 2 yrs.		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause (last).	DUE TO (b) <u>Original melanoma abdominal wall</u>	<u>5 yrs.</u>
	DUE TO (c) <u>190.5</u>	

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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 <u>8 p.</u> Month, Day, Year <u>2/2/60</u>			

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>St. Louis Co, Missouri</u>	COUNTY	STATE
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21. I attended the deceased from 2/2/60 to 2/22/60 and last saw ^{her} live on 2/22/60
Death occurred at 8 p. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Thomas C. Anderson M.D.</u> (Degree or title)	22b. ADDRESS <u>4660 Maryland Ave</u>	22c. DATE SIGNED <u>7/23</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2/24/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Co, Missouri</u>
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24. FUNERAL DIRECTOR <u>Alexander & Sons 6175 Delmar Blvd</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>2-23-60</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>
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DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

Dr.T.C.Birdsal

4660 Maryland Ave

Pho.1-6074

10 to 12 - 2 to 4 P.M.

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 James E. McCullough

Licensed Embalmer No. 290

P. O. Address 6125

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.