

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N GRAND ST LOUIS MO		Length of stay in 1b 68 DAYS	c. CITY OR TOWN ST LOUIS
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION VETS ADMIN HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4424A MC PHERSON

3. NAME OF DECEASED (Type or print) First RALPH Middle E. Last ROSE			4. DATE OF DEATH Month AUGUST Day 22 Year 1960	
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5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4/6/04	9. AGE (last birthday) 56	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done most of working life, even if retired) ROOFER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) CENTRALIA, MO.	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME FRED ROSE	13b. MOTHER'S MAIDEN NAME KATE COX	14. NAME OF HUSBAND OR WIFE MARGUERITE ROSE
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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) YES WW II	16. SOCIAL SECURITY NO. 486-20-1497	17. INFORMANT 4424A MC PHERSON MARGUERITE ROSE ST LOUIS MO.
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) HEMORRHAGE		1 DAY
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) RECURRENT CARCINOMA OF LARYNX	
	DUE TO (c) 161x	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) MALNUTRITION	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
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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 VA	COUNTY	STATE
21. I attended the deceased from 6/15/60 to 8/22/60 and last saw <input checked="" type="checkbox"/> him alive on 8/22/60 Death occurred at 4:35 AM on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE JACK W. LOVE (Degree or title) M.D.	22b. ADDRESS VAH, ST LOUIS, MISSOURI	22c. DATE SIGNED 8/22/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8-25-60	23c. NAME OF CEMETERY OR CREMATORY Lake Charles Cem.	23d. LOCATION (City, town, or county) (State) St. Louis, Co. Mo.
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24. FUNERAL DIRECTOR Jay B. Smith, Maplewood, Mo.	25. DATE RECD. BY LOCAL REG. AUG 23 1960	26. REGISTRAR'S SIGNATURE Carl Smith, M.D.
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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 W E Burgess

Licensed Embalmer No. 402

P. O. Address Maplewood

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