

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-031423

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 7355

AMENDED

FILED AUG 28 1961

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Clayton</b>		Length of stay in 1b <b>12 days</b>	c. CITY OR TOWN <b>Maplewood</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis County Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3613 Oxford</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Beatrice</b> Middle <b>R.</b> Last <b>Rose</b>			4. DATE OF DEATH Month <b>8</b> Day <b>17</b> Year <b>61</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2/27/1906</b>	9. AGE (last birthday) <b>55</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>General Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Laundry</b>	11. BIRTHPLACE (City and state or country) <b>New York</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
13a. FATHER'S NAME <b>Unknown Desante</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No. Nil.</b>			17. INFORMANT Address <b>Charles Rose, St. Louis, Mo.</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 d.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Ruptured congenital aneurysm (R) middle Cerebral</b>	
	DUE TO (c) <b>Multiple aneurysms (congenital) (R) middle Cerebral</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 checked="" 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 8-5-61 to 8-17-61 and last saw her alive on 8-17-61  
Death occurred at 11:20 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Albert L. Howe M.D.</b> (Degree or title)	22b. ADDRESS <b>6013 Brentwood Clayton 5, Mo.</b>	22c. DATE SIGNED <b>8/17/61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>8-21-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Haven, Cemetery</b>
23d. LOCATION (City, town, or county) <b>New Haven, Mo.</b>	24. FUNERAL DIRECTOR ADDRESS <b>L.C. Fertig &amp; Son, New Haven, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>8-22-61</b>
26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>		

DATE AMENDED  
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF  
ITEM NO. SHOULD READ

SEP 7 1961

**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 John J. Haines  
Licensed Embalmer No. 4108

P. O. Address St. Louis

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.