

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

318 Primary Registration District No. 1003 Registrar's No. 10470 -61-039148 STATE FILE NUMBER

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 **Homer G. Phillips** 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) **2439 Laflin** Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First **Will** Middle _____ Last **Rosbon** 4. DATE OF DEATH Month **11** Day **8** Year **61**

5. SEX **Male** 6. COLOR OR RACE **Negro** 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH **10/10/1890** 9. AGE (last birthday) **71** 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) **Freight handler** 10b. KIND OF BUSINESS OR INDUSTRY **none** 11. BIRTHPLACE (City and state or country) **Hines County, Miss.** 12. CITIZEN OF WHAT COUNTRY **U.S.A.**

13a. FATHER'S NAME **Wade Rosbon** 13b. MOTHER'S MAIDEN NAME **Mattie McPhearson** 14. NAME OF HUSBAND OR WIFE **Deceased**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service.) **no** 17. INFORMANT **Aaron Rosebun** Address **1243 N. Garrison**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Arteriosclerotic Heart Disease with Failure** INTERVAL BETWEEN ONSET AND DEATH **Undet.**
DUE TO (b) _____
DUE TO (c) **4-20-0**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) **Cerebral Thrombosis, Decubuti** 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 **10-27-61** to **11-8-61** and last saw **Dr** him alive on **11-8-61**
Death occurred at **9:20** **p.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE **J. H. Utley, M.D.** 22b. ADDRESS **2601 N. Whittier Street** 22c. DATE SIGNED **11-9-61**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 23b. DATE **11/15/61** 23c. NAME OF CEMETERY OR CREMATORY **Washington Park** 23d. LOCATION (City, town, or county) (State) **St. Louis County, Mo.**

24. FUNERAL DIRECTOR **Grant Johnson** ADDRESS **4352 Wash. Blvd.** 25. DATE RECD. BY LOCAL REG. **NOV 10 1961** 26. REGISTRAR'S SIGNATURE **Earl Smith, M.D.**

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

Fred A. Green

Licensed Embalmer No.

2963

P. O. Address

4214 Delme

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.