

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-039660
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 350

AMENDED

FILED NOV 15 1961

DATE AMENDED

INSTEAD OF

DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>St. Clair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Manchester</u>		Length of stay in 1b <u>10 days</u>	c. CITY OR TOWN <u>E. St. Louis</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Manchester Nursing Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>8801 Maple</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>(DR) HERMAN EDWIN ROSE</u>			4. DATE OF DEATH Month Day Year <u>November 7 1961</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-26-1876</u>	9. AGE (last birthday) <u>85</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>11</u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>Oddville, Ky</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Edwin Carter Rose</u>	13b. MOTHER'S MAIDEN NAME <u>Sally Edlizabeth Richards</u>	14. NAME OF HUSBAND OR WIFE <u>Margaret (Jarrell) Rose</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>	17. INFORMANT <u>Mrs. Margaret Rose, 8801 Maple</u>	Address <u>E. St. Louis, Ill</u>
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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: IMMEDIATE CAUSE (a) <u>Cancer of the Nose and Face</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Don't Know</u>
DUE TO (b) _____		
DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Senile Dementia, Senility, Arteriosclerosis</u>		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 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 _____ Month, Day, Year _____ a.m. _____ p.m. _____		

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 _____
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21. I attended the deceased from Oct. 31, 1961 to Nov. 7, '61 and last saw ^{him} alive on Nov. 7, 1961
Death occurred at 4:45 P on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Walter J. Zaffey, M.D.</u> (Degree or title)	22b. ADDRESS <u>Box 122, 1016 Main Rd., Manchester, Mo.</u>	22c. DATE SIGNED <u>11-8-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-10-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla</u>
23d. LOCATION (City, town, or county) <u>St. Louis Missouri</u>		

24. FUNERAL DIRECTOR <u>C. G. Kurrus, Jr., E. St. Louis, Ill</u>	25. DATE RECD. BY LOCAL REG. <u>11-8-61</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>
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ITEM NO. SHOULD READ

BY AFFIDAVIT OF

Embaffey -
Worship Mill & M
(#100 & 141)

1-C

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 _____

Licensed Embalmer No. 2162

P. O. Address East St Lau

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.