

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-040673

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District **1003** Registrar's No. **10431** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 13 1962

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Rev. 4/59

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STATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

1. COUNTY a. COUNTY **St. Louis**

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **Mo.** b. COUNTY

3. CITY (If outside corporate limits, give TOWNSHIP only) **St. Louis** Length of stay in 1b

4. CITY (If outside, give location) **St. Louis** Inside Limits Yes No

5. FULL NAME OF DECEASED (Type or print) **Robert Rose** First Middle Last

6. DATE OF DEATH **10 29 62** Month Day Year

7. SEX **Male** **8. COLOR OR RACE** **Colored** **9. AGE** (last birthday) **68** **10. DATE OF BIRTH** **12/23/1893**

11. MARRIED Never Married Divorced **12. WIDOWED** **13. UNDER 1 YEAR** Months Days **14. UNDER 24 HR** Hours Min.

15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Laborer** **16. KIND OF BUSINESS OR INDUSTRY** **Freight House** **17. BIRTHPLACE** (City and state or country) **St. Charles Mo.** **18. CITIZEN OF WHAT COUNTRY** **U.S.A.**

19. FATHER'S NAME **Alexander Rose** **20. MOTHER'S MAIDEN NAME** **Lucy English** **21. NAME OF HUSBAND OR WIFE**

22. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No.** **23. SOCIAL SECURITY NO.** **24. INFORMANT** **Catherine Carpenter-1408 Shawmut Pl.** Address

25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Cerebral Hemorrhage**
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) **Arterio Sclerosis**
DUE TO (c) **331X**

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. Yes No Unknown

26. WAS AUTOPSY PERFORMED? YES NO **27. ACCIDENT** **28. SUICIDE** **29. HOMICIDE** **30. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in PART I or PART II of item 18.)

31. TIME OF INJURY Hour Month, Day, Year a.m. p.m.

32. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK **33. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.) **34. CITY, TOWN, OR LOCATION** **35. COUNTY** **36. STATE**

37. I attended the deceased from **5-40-15** to **5-40-15** and last saw her alive on **5-40-15** Death occurred at **5-40-15** m on the **29** day stated above, and to the best of my knowledge, from the causes stated.

38. SIGNATURE (Physician or title) **39. ADDRESS** **1500 Clay** **40. DATE SIGNED** **10-31-62**

41. BURIAL, CREMATION, OR REMOVAL (Specify) **Removal** **42. DATE** **11/5/62** **43. NAME OF CEMETERY, OR CREMATORY** **Washington Park** **44. LOCATION** (City, town, or county) **St. Louis, Co., Mo.** (State)

45. FUNERAL DIRECTOR **Metropolitan Funeral System** **46. ADDRESS** **3010 Erie** **47. DATE RECD. BY LOCAL REG.** **OCT 31 1962** **48. REGISTRAR'S SIGNATURE** **Bob Smith: M.D.**

USE BLACK INK OR TYPEWRITER RIBBON

[Faint, mostly illegible text and markings at the top of the page, possibly bleed-through from the reverse side.]

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 R. Pennington

Licensed Embalmer No. 4496
P. O. Address 2405 Marine

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.