

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-037310

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 311 Primary Registration District No. 6075 Registrar's No. 392

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 8 1963

1. PLACE OF DEATH a. COUNTY St. Francois		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis County	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Francois Township		Length of stay in 1b 51Y; 7M; 7das	c. CITY OR TOWN Webster Groves Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital No. 4		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Unknown Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First SHELBY Middle V. Last ROSEN			4. DATE OF DEATH Month September Day 21 Year 1963		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Feb. 14, 1890	9. AGE (last birthday) 73	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) St. Louis, Mo.	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME August F. Rosen		13b. MOTHER'S MAIDEN NAME Phillipa Andre	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. _____	
17. INFORMANT Records, State Hospital No. 4, Farmington, Mo.		17. INFORMANT Address		18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:	

IMMEDIATE CAUSE (a) Gastric hemorrhage, massive		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
DUE TO (b) Carcinoma of the stomach		Abt. 5 mos.
DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). Dementia Praecox Psychosis.		
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		

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 Farmington, Missouri	COUNTY _____ STATE _____
21. I attended the deceased from Sept. 20, 1963 to Sept. 21, 1963 and last saw him <input checked="" type="checkbox"/> alive on Sept. 21, 1963 Death occurred at 6:05 P. M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>John A. Brennan M.D.</i>		22b. ADDRESS State Hospital No. 4 Farmington, Missouri	22c. DATE SIGNED 9-21-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9-24-63	23c. NAME OF CEMETERY OR CREMATORY Washington Univ. Medical School, St. Louis, Missouri	
24. FUNERAL DIRECTOR Cozean Funeral Home, Farmington, Missouri		25. DATE RECD. BY LOCAL REG. Sept. 24, 1963	26. REGISTRAR'S SIGNATURE <i>Ethel Rudloff</i>

(Licensed Embalmer's Statement on Reverse Side)

VS-300 Rev. 4/59
10940
24007
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4 **0**
5 **0**
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8 **2**
9/51X
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13 **10**

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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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

not embalmed

Signed _____

McGowan

Licensed Embalmer No. _____

4084

R.O. Address _____

Langston Ms

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.

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