N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
JAN 12 1940 791

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 41339

Registration District No. 1003 Primary Registration District No. Registrar's No. 10462

1. PLACE OF DEATH:

(a) County /

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Anthony's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED: /

(a) State Missouri (b) County

(c) City or town St. Louis 16
(If outside city or town limits, write "RURAL")

(d) Street No. 3901 Keokuk St.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Fred F. Rose Jr. 200

3. (b) If veteran, name war None

3. (c) Social Security No. 492-05-4989

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mary Rose

6. (c) Age of husband or wife if alive 32 years

7. Birth date of deceased November (Month) 26 (Day) 1903 (Year)

8. AGE: Years 36 Months 0 Days 9 If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)

10. Usual occupation Commercial Agent

11. Industry or business Gulf Pacific S.S. Lines

FATHER
12. Name Fred Rose Sr.
13. Birthplace (City, town, or county) Ohio (State or foreign country)

MOTHER
14. Maiden name Maria Sittel
15. Birthplace (City, town, or county) Mo. (State or foreign country)

16. (a) Informant's own signature Mary Rose
(b) Address 3901 Keokuk St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-8-39 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Kriegshauser Mortuaries
(b) Address 4228 So. Kingshighway

19. (a) DEC 6 1939 (Date received local registrar) (b) J. F. Bredick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 5th year 1939 hour 7:40 minute P.M. M.

21. I hereby certify that I attended the deceased from Aug 30 1938, 19 to Dec 5, 1939 that I last saw him alive on Dec 5, 1939 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cardio-Vascular-Renal Disease	16 Mo
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) —

(b) Date of occurrence —

(c) Where did injury occur? — (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? — (Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] M.D. (M. D. or other)

Address 5417 So Grand Date signed 12-6-39

(Licensed Embalmer's Statement on Reverse Side)

So. Grand Blvd.
11-1

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Edwin D McDermott

Licensed Embalmer No. 3024

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.