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FILED MAR 11 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6361

Registration District No. 85 Primary Registration District No. 1001 Registrar's No. 241

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St. Joseph (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Mo. Meth. Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Died At door before (Specify whether
In this community 34 YEARS. Entering years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Buchanan
(c) City or town St Joseph (If outside city or town limits, write "RURAL")
Street No. 818 1/2 Locust 7 (If rural, give location)
(e) If foreign born, how long in U. S. A.? 34 Yrs. years.

3. (a) PRINT FULL NAME MAX ROSEN
3. (b) If veteran, name war NONE
3. (c) Social Security No. NONE
4. Sex MALE
5. Color or race Wht.
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife Sophie Rosen
6. (c) Age of husband or wife if alive 67 years
7. Birth date of deceased MAY (Month) 18 (Day) 1878 (Year)

8. AGE: Years 62 Months 9 Days 9 If less than one day ___ hr. ___ min.

9. Birthplace UNKNOWN (City, town, or county) Poland (State or foreign country)
10. Usual occupation Merchant
11. Industry or business Cap Mfg. Co. prop.
FATHER
12. Name UNKNOWN
13. Birthplace UNKNOWN (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name UNKNOWN
15. Birthplace UNKNOWN (City, town, or county) (State or foreign country)
16. (a) Informant JOE. ROSEN
(b) Address 2603 Union St. Joseph, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-28-41 (Month) (Day) (Year)
(c) Place: burial or cremation Shaare Sholem
18. (a) Signature of funeral director FLEEMAN & SON, INC.
(b) Address St. Joseph, Mo.
19. (a) 2/28/1941 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 27 year 1941 hour 9:01 minute A M.
21. I hereby certify that I ~~attended~~ viewed the deceased ~~from~~ on Feb 27, 1941, to ___, 19___;
that I last saw him ___, 19___;
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion

Due to

Due to 94 W

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy no

Duration

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? 85 (Specify type of place)
While at work? (e) Means of injury ?

23. Signature H F Mundy (M. D. ~~or other~~) Coroner
Address 404 So 3d ST. JOSEPH Date signed 2/27/41

(Licensed Embalmer's Statement on 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.....

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

working under my personal supervision.

Body Not Embalmed. Signed.....

Licensed Embalmer No.....

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, fact should be so stated above.