NO. 2
-1-4-41
5-17-39
I X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 8 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 29487

Registration District No. 784 Primary Registration District No. 200 Registrar's No. 1773

1. PLACE OF DEATH:

(a) County: ST LOUIS

(b) City or town: KOCH (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Robert Koch Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 597 days (Specify whether years, months or days)

In this community: Life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: St Louis 008 17 9

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

(d) Street No. 4101 Labadie (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: OTTO ROSE

3. (b) If veteran, name war: None.

3. (c) Social Security No. 497-09-3507

4. Sex: male

5. Color or race: white

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

6. (b) Name of husband or wife: Edna Rose nee Grant

6. (c) Age of husband or wife if alive: 49 years

7. Birth date of deceased: Sept (Month) 7 (Day) 1885 (Year)

8. AGE: Years 55 Months 11 Days 19 If less than one day ____ hr. ____ min.

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

10. Usual occupation: Porter

11. Industry or business: Famous Barr Co.

FATHER 12. Name: Fred Rose

FATHER 13. Birthplace: Germany (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name: Christine Panier

MOTHER 15. Birthplace: Germany (City, town, or county) (State or foreign country)

16. (a) Informant: Hospital Record

(b) Address: Robert Koch Hospital

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/29/41 (Month) (Day) (Year)

(c) Place: burial or cremation: Hiram Park Cemetery

18. (a) Signature of funeral director: Math Hermann & Son

(b) Address: 2161 East Fair Ave

19. (a) AUG 27 1941 (Date received by local registrar) Ed J McGauran MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 26 year 1941 hour 12 minute 15 A.M.

21. I hereby certify that I attended the deceased from Jan 6 1940 to Aug 26 1941; that I last saw him alive on Aug 26 1941; and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary Tuberculosis — Duration: 16 years +

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: Frank Cohen (M. D. or other) M.D.

Address: Robert Koch Hospital Date signed: Aug 26/41

(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.

Signed. Lorenzo Hampton

Licensed Embalmer No. 2967

P. O. Address St. Louis, Mo.

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

If this body is not embalmed, fact should be so stated above.