

No. 2
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17-39
X3588

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3262A

ED OCT 2 - 1943

Registration District No. 37

Primary Registration District No. 3069

State File No. _____

Registrar's No. 2157

1. PLACE OF DEATH:

(a) County St. Louis

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

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

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

In this community _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Vinita Terrace. 096
(If outside city or town limits, write "RURAL")

(d) Street No. 8038 Madison
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME AMELIA B. ROSE.

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Alois J. Rose 6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased Nov. 2nd 1893
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>49</u>	<u>10</u>	<u>21</u>	_____ hr. _____ min.

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

10. Usual occupation At home

11. Industry or business _____

MOTHER FATHER {

12. Name John FORSTER

13. Birthplace unknown Germany 4
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Reising.

15. Birthplace unknown Illinois 1
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Alois J. Rose.

(b) Address 8038 Madison,

17. (a) burial (b) Date thereof Sept. 27/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine Cem.

18. (a) Signature of funeral director C.R. Lupton & Sons.

(b) Address 7233 Delmar Blvd.

19. (a) SEP 24 1943 (b) C. J. McHaren
(Date received from informant) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 23rd
year 1943 hour 4:45 minute P. M.

21. I hereby certify that I attended the deceased from June 10 1943 to Sept 23 1943
that I last saw her alive on Sept 23 1943
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Cancer - Generalized Carcinomatous 3 months

Due to Cystic Nodules Rt.

Other conditions _____
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings: Multiple Metastases
Of operations nodules Liver Spleen

Of autopsy smearings

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) C

(b) Date of occurrence 4

(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? _____

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

23. Signature Dr. J. Reel Date signed 9-24-43
Address 8105 Page Ave

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

MAR 1 1950

WI-1021
Hrs.-10-11 A.M.

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 Bradford A. Miles

Licensed Embalmer No. 2901

P. O. Address University City

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

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *oct*

Registration District No. *317* Primary Registration District No. *3069* Registrar's No. *2157*

1. PLACE OF DEATH
(a) County *St Louis*
(b) City or town *Richmond Heights*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. (Specify whether years, months or days)

3. (a) PRINT FULL NAME *Amelia B. Rose*
3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex *F* 5. Color or race *w* 6. (a) Single, widowed, married, divorced *m*
6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive. years
7. Birth date of deceased *Nov 2*
(Month) (Day) (Year)

8. AGE: Years *49* Months *10* Days *18* If less than one day, min.

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name (City, town, or county) (State or foreign country)

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Sept* day *21* year *1943* hour minute M.

21. I hereby certify that I attended the deceased from 19...; that I last saw him/her alive on 19...; and that death occurred on the date and hour stated above.

Immediate cause of death: *Cancer Generalized Carcinomatosis Primary Seat of ea*

Due to: *pt. 6 mo*

Due to: *cystic ovary pt. 490*

Other conditions (Include pregnancy within 3 months of death)

Ca
Major findings: *multiple metastatic nodules in spleen & mesentery*
Of operations
Of autopsy
Underline 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?

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

23. Signature *R. W. Kullgren* (M. D. or other)

Address Date signed

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

SUPPLEMENTARY

MOTHER FATHER

MAR 10 1924

32024

MAY 2 19