No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
U. S. BUREAU OF THE CENSUS
FILED JUN 9 1944

STATE BOARD OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 16712

Registration District No. 318 | Primary Registration District No. 1003 | Registrar's No. 5062

**1. PLACE OF DEATH:**
(a) County
(b) City or town St. Louis Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 4212 Botanical Ave
(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 60 Yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Mo (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4212 Bontanical Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Charles A Rozier
3. (b) If veteran, name war No
3. (c) Social Security No. No
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Annie
6. (c) Age of husband or wife if alive 72 years
7. Birth date of deceased Oct (Month) 5 (Day) 1860 (Year)
8. AGE: Years 83 Months 7 Days 26 If less than one day hr. min.
9. Birthplace St. Geneivene (City, town, or county) Mo (State or foreign country)
10. Usual occupation Retired Mercantile Business
11. Industry or business Own
FATHER
12. Name C. C. Rozier
13. Birthplace St Geneivene (City, town, or county) Mo (State or foreign country)
MOTHER
14. Maiden name Mimi La Grane
15. Birthplace St Geneiveni (City, town, or county) Mo (State or foreign country)
16. (a) Informant Annie Rozier
(b) Address 4212 Bontanical Ave
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 (Month) 3 (Day) 44 (Year)
(c) Place: burial or cremation Sunset Burial Park
18. (a) Signature of funeral director Kriegshauser Und Co
(b) Address 4223 So. Kinghighway
19. (a) JUN 2 1944 (Date received local registrar) J. F. Medeck (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month June day 1 year 1944 hour 12,50 AM minute M.
21. I hereby certify that I attended the deceased from May 15 1944 to June 1 1944 that I last saw him alive on June 1 1944 and that death occurred on the date and hour stated above.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | 1 wk |
| Due to arteriosclerosis | 5 years |
| Due to senility | |
| Other conditions none (Include pregnancy within 3 months of death) | |
| Major findings: Of operations none | |
| Of autopsy no | |

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 W. H. Clutterow (M. D. or other)
Address 906 Carleton Bldg Date signed 6-2-44

(Licensed Embalmer's Statement on Reverse Side)

Carter Bldg 308 N 6th
11 AM.

## 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 Richard W Storrsand

Licensed Embalmer No. 4007

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.**