

S. No. 2
FORM-5-43
Rev. 5-17-39
X36671

DEPARTMENT OF HEALTH
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

40120

State File No. _____
Registrar's No. 10616

FILED NOV 28 1947
318
Registration District No. _____
Primary Registration District No. _____

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

1. PLACE OF DEATH:

(a) County St. Louis, Mo

(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:
2525 Newhouse 1
(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 Theresa Rosenberger

3. (b) If veteran, name war No

3. (c) Social Security No. 487-14-488A

4. Sex F / 5. Color or race W

6. (a) Single, widowed, married, divorced Widow 2

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Mar 12 1881
(Month) (Day) (Year)

8. AGE: Years 66 Months 8 Days 6 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Joseph Deutch 4

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

14. Maiden name Anna Tomcits 4

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

16. (a) Informant Alois Tomcits

(b) Address 6219 Green-Pine Lane Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 20 47
(Month) (Day) (Year)

(c) Place: burial or cremation St. Calvard

18. (a) Signature of funeral director Edward Koch + Son

(b) Address 3716 N. 14th - St. Louis

19. (a) NOV 18 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County ado

(c) City or town St. Louis Mo 47
(If outside city or town limits, write "RURAL")

(d) Street No. 2525 Newhouse 9
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 18 year 1947 hour _____ minute 7:45 M.

21. I hereby certify that I attended the deceased from May 28 1947 to Nov 18 1947 that I last saw her alive on Nov 14 1947 and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Due to myocardial infarction

Due to hypertension

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? _____

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

23. Signature J. P. Phylp (M. D. number) _____
Address 2545 Newhouse St. Date signed _____

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 Ronald Jaburke

Licensed Embalmer No. 3917

P. O. Address.....

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.