

10-47  
17-39  
I 3906

FILED JUL 6 1948  
Registration District No. 27

Primary Registration District No. 2002

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

1. PLACE OF DEATH:  
 (a) County St. Louis  
 (b) City or town University City  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
6255 Delmar Blvd.  
(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 Robert B. Rose  
 3: (b) If veteran, name war \_\_\_\_\_  
 3: (c) Social Security No. \_\_\_\_\_

4. Sex M. Color or race W.  
 6: (a) Single, widowed, married, divorced M.  
 6: (b) Name of husband or wife Dorothy Rose  
 6: (c) Age of husband or wife if alive 26 years  
 7. Birth date of deceased Aug. 27th., 1918  
(Month) (Day) (Year)

8. AGE: Years 29 Months 9 Days 6  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)  
 10. Usual occupation Real Estate Salesman

11. Industry or business \_\_\_\_\_  
 12. Name Robert E. Rose  
 13. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)  
 14. Maiden name Cordelia Wacha  
 15. Birthplace Ky.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Dorothy Rose  
 (b) Address 6255 Delmar Blvd.  
 17. (a) Burial (b) Date thereof 6-9-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary  
 18. (a) Signature of funeral director Arthur J. Donnelly  
 (b) Address 3840 Lindell Blvd.  
 19. (a) 6-7-48 (b) Arthur J. Donnelly  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo. (b) County St. Louis  
 (c) City or town University City  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 6255 Delmar Blvd.  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month June day 6th., year 1948 hour 5 minute 45 a. M.

21. I hereby certify that I attended the deceased from Jan. 1, 1944, 19\_\_\_\_ to June 6, 1948  
 that I last saw him alive on June 5, 1948  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral arteriosclerosis with apoplexy  
 Duration 3 mo.

Due to \_\_\_\_\_ 61  
 Due to \_\_\_\_\_

Other conditions Diabetes - since 1944 - I know about it  
(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) \_\_\_\_\_  
 (a) Means of injury \_\_\_\_\_  
 23. Signature Dr. William M. D. (M., D., or other) \_\_\_\_\_  
 Address 6336 Clayton Road Date signed 6/7/48

1 year to 3 years.

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**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 Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address 3840 Lindell

**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.**