

National Office of Vital Statistics
FILED JUL 22 1948
Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County.....
 (b) City or town..... St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 4216a Shenandoah /
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
 (Specify whether
 In this community.....
 years, months or days)

3. (a) PRINT

FULL NAME ROSE A. TAYLOR

3. (b) - If veteran,

name war..... None

3. (c) Social Security No.

4. Sex..... Female 5. Color or race..... White
 6. (a) Single, widowed, married,
divorced..... Widow
 6. (b) Name of husband or wife..... Late Charles A.
 6. (c) Age of husband or wife if
 alive..... years
 7. Birth date of deceased..... Nov. 3 1868
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
79 8 5 hr. min.

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

10. Usual occupation..... Housework

11. Industry or business

12. Name..... Frederick Engel
 13. Birthplace..... St. Louis Mo.
 (City, town, or county) (State or foreign country)
 14. Maiden name..... Elizabeth Krallmann
 15. Birthplace..... Germany
 (City, town, or county) (State or foreign country)

16. (a) Informant..... H. W. Heald
 (b) Address..... 4902 Itaska St.
 17. (a) Cremation (b) Date thereof..... 7-12-48
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation..... Valhalla Crematory

18. (a) Signature of funeral director..... Kriegshauser Und. Co.
 (b) Address..... 4228 S. Kingshighway Bl.
JUL 9 1948
 19. (a) (Date received local registrar) (b) J. F. Bredbeck
 (Registrar's signature)

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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. 4216a Shenandoah
 (If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... July day..... 8
 year..... 1948 hour..... 6:30 minute..... PM

21. I hereby certify that I attended the deceased from.....
 19..... to..... 19.....
 that I last saw her alive on..... July 7th 19.....
 and that death occurred on the date and hour stated above.
 Immediate cause of death..... M. Zoonosis
 Duration

Due to..... Hypertension & C.V.R. by

Due to.....

Other conditions.....
 (Include pregnancy within 3 months of death) 1/21

Major findings:
 Of operations.....

Of autopsy.....

PHYSICIAN

Underline
 the cause of
 which death
 should be
 charged sta-
 tistically.

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..... O. K. Kerpel (M. D. or other) MD
 Address..... 2500 B. Chippewa Date signed..... 7/12/48

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. Stovesand

Licensed Embalmer No. 4007

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. July

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 6122

1. PLACE OF DEATH:

(a) County.....
 (b) City or town St Louis
(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
 In this community.....
years, months or days)

3. (a) PRINT FULL NAME

Rose A. Taylor

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 wid

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

7. Birth date of deceased hr. 3
(Month) (Day) (Year)

8. AGE: Years 79 Months 8 Days 10
(If less than one day, hr. min.)

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....
 { 13. Birthplace.....
(City, town, or county) (State or foreign country)
 { 14. Maiden name.....
 { 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.....

13. (a) Signature of funeral director.....

(b) Address.....

19. (a) 7-9-1948 (b) J. F. Busch
(Date received local registrar) (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.....
 year 1948 hour..... minute..... M.

21. I hereby certify that I attended the deceased from.....
 to....., 19.....
 that I last saw him..... alive on....., 19.....
 and that death occurred on the date and hour stated above.
 Immediate cause of death.....

Duration

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?.....

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

23. Signature..... (M. D. or other).....

Address..... Date signed.....

SUPPLEMENTARY

S-24784

2