

No. 300
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5-17-39
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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **28166**
7681
Registrar's No. _____

FILED SEP 13 1948 **918**

Registration District No. _____ Primary Registration District No. **1003**

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

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:
5617 Enright 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 _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME MARTIN ROSSEN

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mary G. Rossen

6. (c) Age of husband or wife if alive 35 years

7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE: Years About 39 Months _____ Days _____
If less than one day hr. min.

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

10. Usual occupation Lawyer

MOTHER FATHER

11. Industry or business _____

12. Name Joseph Rossen

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

14. Maiden name Beckie Rochman

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

16. (a) Informant Mary Rossen

(b) Address 5617 Enright Ave.

17. (a) Burial (b) Date thereof 9-1-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chesed Shel Emeth Cem. Herman Rindskopf, Inc.

18. (a) Signature of funeral director _____

(b) Address 5216 Delmar Blvd.

19. (a) AUG 31 1948 (b) J. F. Brodeur
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

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

(d) Street No. 5617 Enright Ave.
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 30
year 1948 hour 8 minute 7 M.

21. I hereby certify that I attended the deceased from March 2, 1948 to Aug 20, 1948
that I last saw him alive on Aug 30, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia Duration 1 wk

Due to Laceration of Head of forehead 7 mos.

Due to _____

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

Major findings: Laceration of forehead with metastasis to liver

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? _____

(e) Means of injury _____
(Specify type of place)

While at work? _____

23. Signature Harold Schiff (M. D. or other) _____
Address 607 N. Grand Date signed 8/31/48

3751 87 036

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.....

John Kettles

Licensed Embalmer No.....

3890

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.