

FILED SEP 2- 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28491

State File No. 7471

BIRTH NO.		REG. DIST. NO. 318	PRIMARY REG. DIST. NO. 1003	Registrar's No.
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before death) a. STATE MO b. COUNTY St. Louis 41		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 9		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN University City 3		
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hosp.		STREET ADDRESS 7745 Olive St. Rd. 5		
3. NAME OF DECEASED (Type or Print) a. (First) Charles - 7. - Rosenbergs		b. (Middle)		c. (Last)
4. DATE OF DEATH (Month) (Day) (Year) Aug. 23 - 1949				
5. SEX MO	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH Jan 31 - 1895	9. AGE (In years last birthday) 54
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Doctor		10b. KIND OF BUSINESS OR INDUSTRY M.D.	11. BIRTHPLACE (State or foreign country) E. St. Louis Ill	12. CITIZEN OF WHAT COUNTRY? U.S.A
13a. FATHER'S NAME Val Rosenbergs		13b. MOTHER'S MAIDEN NAME Louise Litweiken		14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) cerebral thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) hypertension DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH 3 weeks.
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 102		
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? H H H X		
22. I hereby certify that I attended the deceased from Aug. 20 th 1949, to Aug. 23, 1949, that I last saw the deceased alive on Aug. 23, 1949, and that death occurred at 5:40 p. m., from the causes and on the date stated above.				
23a. SIGNATURE Hermann Maas M.D.		23b. ADDRESS Metropolitan Bldg. 508 No. Grand Ave.		23c. DATE SIGNED 8-24-49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Aug. 29, 1949	24c. NAME OF CEMETERY OR CREMATORY Mt Hope	24d. LOCATION (City, town, or county) (State) Belleville Ill	
DATE REC'D BY LOCAL REG. AUG 29 1949	REGISTRAR'S SIGNATURE J. B. Foster	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Lucius H. Boff Inc. Parkwood Mo		

(Licensed Embalmer's Statement on Reverse Side)

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

1202

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Felix Durand

Licensed Embalmer No. 3034

P. O. Address Kirkwood (22)

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.