

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6734

State File No.

BIRTH NO. FILED MAR 4 1954 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1426

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Illinois</u> b. COUNTY <u>St. Clair</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Missouri</u>	c. LENGTH OF STAY (in this place) <u>1 week</u>	c. CITY OR TOWN <u>East St. Louis</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		e. STREET ADDRESS (If rural, give location) <u>1824 Gay Avenue</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Nick</u>	b. (Middle) <u>NMN</u>	c. (Last) <u>Rose</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 13 54</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>5-1-1899</u>	9. AGE (In years last birthday) <u>54</u>	IF UNDER 1 YEAR Months <u>9</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>self-employed</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>woodman</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Macon, Mississippi</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Bill Rose</u>	13b. MOTHER'S MAIDEN NAME <u>Linda ?</u>	14. NAME OF HUSBAND OR WIFE <u>Laura Lee Rose</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>410-48-5312</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Laura Lee Rose</u>	ADDRESS <u>1824 Gay</u>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral arteriosclerosis</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>334x</u>
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22. I hereby certify that I attended the deceased from Feb. 5, 1954, to Feb. 13, 1954, that I last saw the deceased alive on Feb. 13, 1954, and that death occurred at 4:00A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>H. R. Brantley, M.D.</u>	23b. ADDRESS <u>BARNES HOSPITAL</u>	23c. DATE SIGNED <u>2/13/54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>2-15-54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Brookier Washington</u>	24d. LOCATION (City, town, or county) (State) <u>East St. Louis, Illinois</u>
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DATE REC'D BY LOCAL REG. <u>FEB 15 1954</u>	REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>W. V. Wash</u>	ADDRESS <u>111 North 13th St.</u>
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WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

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.....
Signature of Student Embalmer

Signed..... *C. J. Nash*

Licensed Embalmer No. *24*
P. O. Address *28470*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.