

FILED MAY 6 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14027**

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

Registrar's No. **3827**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS, MISSOURI		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL		e. STREET ADDRESS (If rural, give location) 22 2701a Chouteau	
3. NAME OF DECEASED (Type or Print) a. (First) EMMA b. (Middle) c. (Last) ROSE		4. DATE OF DEATH (Month) (Day) (Year) APRIL 26, 1954	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Feb 27 1874
9. AGE (In years last birthday) 80		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady Owner	
11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Louis Rose		13b. MOTHER'S MAIDEN NAME Rosine Mohart	
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 Mary Schoenefeld 2701a Chouteau	
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) Bronchopneumonia ANTECEDENT CAUSES DUE TO (b) Senility DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Chronic brain syndrome assoc. with senile brain disease.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) 491X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from 4-2-54 , 19___, to 4-26-54 , 19___, that I last saw the deceased alive on 4-26-54 , 19___, and that death occurred at 10:45Am. , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) Kathleen Smith, MD		23b. ADDRESS 1515 Lafayette Avenue	
23c. DATE SIGNED 4-26-54		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE Apr 29 54		24c. NAME OF CEMETERY OR CREMATORY Valhalla	
24d. LOCATION (City, town, or county) (State) St. Louis Cty Mo		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS E.J. Schnur 3125 Lafayette	
DATE REC'D BY LOCAL REG. APR 29 1954		REGISTRAR'S SIGNATURE J. Carl Smith MD <i>(Licensed Embalmer's Statement on Reverse Side)</i>	

WRITE PLAINLY—USING UNFADING 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 *Thomas R. Devereux*.....

Licensed Embalmer No. *379*

P. O. Address *3/250 Lafayette*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.