

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **20729**

FILED JUL 7 - 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500** Registrar's No. **1384**

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY OR TOWN <b>Ellisville</b>	c. LENGTH OF STAY (in this place) <b>2 yrs</b>	c. CITY OR TOWN <b>Ellisville ?</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Sunset Sanitarium</b>		STREET ADDRESS (If rural, give location) <b>Sunset Sanitarium</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>MINNIE</b>	b. (Middle)	c. (Last) <b>ROSEN</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>June 17 1955</b>
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5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>ab. 1898</b>	9. AGE (In years last birthday) <b>ab. 57</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Poland</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>(unk) Luboshitz</b>	13b. MOTHER'S MAIDEN NAME <b>(unknown)</b>	14. NAME OF HUSBAND OR WIFE <b>Haskle Rosen</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Armin Bain</b>	ADDRESS <b>7570 Byron, Clayton, Mo</b>
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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		INTERVAL BETWEEN ONSET AND DEATH <b>9 days</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Staphylococcal Septicemia (meningitis)</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Brain tumor</b>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <b>0531</b>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **4-7**, 19**51**, to **17 June**, 19**55**, that I last saw the deceased alive on **17 June**, 19**55**, and that death occurred at **7:00 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>H. Barnett, M.D.</b>	(Degree or title) <b>D</b>	23b. ADDRESS <b>9929 Manchester Rd, K. C. 24, MO</b>	23c. DATE SIGNED <b>6-18-55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	24b. DATE <b>6/18/55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Highland Cem.</b>	24d. LOCATION (City, town, or county) (State) <b>Wichita Kansas</b>
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DATE REC'D BY LOCAL REG. <b>6/18/55</b>	REGISTRAR'S SIGNATURE <b>Herbert R. Donke, M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Berger Memorial</b>	ADDRESS <b>4715 McPherson</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

0.300  
0.48

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 ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed..... *Sawyer J. Dini*

Licensed Embalmer No. *398*

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.