

FILED OCT 10 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29359

BIRTH NO. _____ REG. DIST. NO. 29 PRIMARY REG. DIST. NO. 4170 Registrar's No. 46

1. PLACE OF DEATH a. COUNTY DeKalb		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY DeKalb	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Union Star		c. LENGTH OF STAY (In this place) 5 yrs	c. CITY OR TOWN Union Star
d. FULL NAME OF HOSPITAL OR INSTITUTION		f. STREET ADDRESS (If rural, give location) 0220	

3. NAME OF DECEASED (Type or Print) a. (First) Ethridge b. (Middle) M. c. (Last) Rosenbaum			4. DATE OF DEATH (Month) (Day) (Year) Oct. 2, 1955		
5. SEX Male C	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 8, 1884	9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shop operator		10b. KIND OF BUSINESS OR INDUSTRY Tire shop	11. BIRTHPLACE (City and State or Foreign Country) Adair Co. Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Peter Rosenbaum	13b. MOTHER'S MAIDEN NAME Ann Loy	14. NAME OF HUSBAND OR WIFE Lena Rosenbaum
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Mrs Lena Rosenbaum	ADDRESS Union Star
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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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>arterio sclerosis</u>		<u>Months</u>
	DUE TO (c) <u>331X</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

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)
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 9-29, 1955, to 10-2, 1955, that I last saw the deceased alive on 10-1, 1955, and that death occurred at 3:00a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>M. J. C. King City MO</u>	23b. ADDRESS <u>King City MO</u>	23c. DATE SIGNED <u>10-2-55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE <u>Oct. 4, 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Plymouth</u>	24d. LOCATION (City, town, or county) (State) <u>Braymer Missouri</u>
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DATE REC'D BY LOCAL REG. <u>10-8-55</u>	REGISTRAR'S SIGNATURE <u>Roscoe Warrick</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Roland D Black</u>	ADDRESS <u>King City, MO</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

300
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 *Roland D. Clark*.....

Licensed Embalmer No. *447*.....

P. O. Address *King City*.....

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.