

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030193

FILED VS SEP 15 1959

Registration District No. 316 Primary Registration District No. - Registrar's No. 349

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis County</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Francois Township</u>		Length of stay in 1b <u>28Y; 5M; 18das.</u>		c. CITY OR TOWN <u>Vinita Park</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital No. 4</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (if outside, give location) <u>Unknown</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>K.</u> Last <u>ROSEMANN</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>9</u> Year <u>1959</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 12, 1886</u>	9. AGE (last birthday) <u>72</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>27</u>	IF UNDER 24 HR Hours <u></u> Mia. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY <u>Germany (?)</u>		
13a. FATHER'S NAME <u>William Schmitz</u>			13b. MOTHER'S MAIDEN NAME <u>Catherine Funks</u>			14. NAME OF HUSBAND OR WIFE <u>Otto Rosemann</u>		
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>Unknown</u>		17. INFORMANT Address <u>Records, State Hospital No. 4, Farmington, Mo.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Gastric hemorrhage - - - - -</u>						<u>Abt. 3 mos.</u>		
DUE TO (b) <u>Carcinoma of the stomach with metastasis into the spine and pelvic bones - - - - -</u>						<u>Abt. 5 mos.</u>		
DUE TO (c) <u></u>						<u></u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Dementia Praecox Psychosis - - - Abt. 25 yrs.</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)				
20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u>			20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE		
21. I attended the deceased from <u>June 11, 1959</u> to <u>Sept. 9, 1959</u> and last saw her <u>live on 9-9-59</u> Death occurred at <u>5:30 A. M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>J. A. Brenner, M.D.</u>				22b. ADDRESS <u>State Hospital No. 4 Farmington, Missouri</u>		22c. DATE SIGNED <u>9-9-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-10-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Calvary Cemetery</u>		23d. LOCATION (City, town, or county) <u>Farmington, Mo.</u>		23e. (State)		
24. FUNERAL DIRECTOR ADDRESS <u>Miller Funeral Home, Farmington, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>Sept. 10, 1959</u>		26. REGISTRAR'S SIGNATURE <u>Cather Rudloff</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Paul K. Buzgal

Licensed Embalmer No. 4126

P. O. Address Farmington

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.