

318

1003

2287

STATE FILE NUMBER

AMENDED

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

FILED VS MAR 16 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b -----	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>De Paul Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>8548 Riverview Blvd., 15</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>T.</b> Last <b>ROSE</b>	4. DATE OF DEATH Month <b>March</b> Day <b>7th</b> Year <b>1961</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>July 8, 1893</b>	9. AGE (last birthday) <b>67</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Superintendent</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Shoe</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>George Rose</b>	13b. MOTHER'S MAIDEN NAME <b>Elizabeth Riley</b>	14. NAME OF HUSBAND OR WIFE <b>Isabella Rose</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>159-69-766</b>	17. INFORMANT <b>Isabella Rose, 8548 Riverview Blvd., 15</b>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR ACCIDENT</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>CEREBRAL HEMORRHAGE</b>	<b>4 days</b>
	DUE TO (c) <b>CEREBRAL ARTERIOSCLEROSIS</b>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>331X</b>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____
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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
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21. I attended the deceased from **SAT. MARCH 4, 1961** to **MARCH 7, 1961** and last saw him alive on **MARCH 6, 1961**  
Death occurred at **7:30 AM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Deceased or title) <b>John Riley M.D.</b>	22b. ADDRESS <b>Ma Theatre Bldg</b>	22c. DATE SIGNED <b>3/7/61</b>
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23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>3-9-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>
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24. FUNERAL DIRECTOR <b>CALVIN F. FEUTZ, 4828 Natural Bridge Blvd., St. Louis, 15, Missouri</b>	25. DATE RECD. BY LOCAL REG. <b>MAR 8 1961</b>	26. REGISTRAR'S SIGNATURE <b>Loard Smith, M.D.</b>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

APR 20 1961

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 Robert E. Mahleman

Licensed Embalmer No. 4916

P. O. Address St. Louis, Mo

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.