

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-037581  
STATE FILE NUMBER

Registration District No. 383 Primary Registration District No. 5655 Registrar's No. 2897

**FILED OCT 23 1961**

1. PLACE OF DEATH a. COUNTY <b>Lawrence</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 (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Mt. Vernon</b>		c. CITY OR TOWN <b>Kirkwood 22</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>Mo. State Sanatorium</b>		d. STREET ADDRESS (If outside, give location) <b>311 Sante</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Odessa</b> Middle <b>Rose</b> Last <b>Rose</b>		4. DATE OF DEATH Month <b>October</b> Day <b>13</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</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>5-1-97</b>
9. AGE (last birthday) <b>64</b>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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	11. BIRTHPLACE (City and state or country) <b>Missouri</b>
12. CITIZEN OF WHAT COUNTRY <b>U. S.</b>		13a. FATHER'S NAME <b>Jeffrey D. Phillips</b>	
13b. MOTHER'S MAIDEN NAME <b>Addie Phillips</b>		14. NAME OF HUSBAND OR WIFE <b>Hugh Lee Rose</b>	
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>none</b>	17. INFORMANT Address <b>San. Records, Mt. Vernon, Mo.</b>
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>Pulmonary tuberculosis, far advanced</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>
DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Carcinoma of cervix (6 mo.); Duodenal ulcer (6 mo.)</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
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ p.m. Month, Day, Year _____			
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 <b>4-29-61</b> to <b>10-13-61</b> and last saw her <del>xxx</del> alive on <b>10-13-61</b> Death occurred at <b>3:50</b> <b>A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>J. Vernon Langsting, M.D.</i> (Degree or title)		22b. ADDRESS <b>Mo. S. S., Mt. Vernon, Mo.</b>	22c. DATE SIGNED <b>10-13-61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10-19-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Father Dickson</b>	23d. LOCATION (City, town, or county) (State) <b>Crestwood Mo.</b>
24. FUNERAL DIRECTOR <b>John W. Hemphill</b> ADDRESS <b>408 S. Fillmore</b>		25. DATE RECD. BY LOCAL REG. <b>10-23-61</b>	26. REGISTRAR'S SIGNATURE <i>Harold L. ... M.D.</i>

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NS 007 2 3 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 Jeffie E. Cooper

Licensed Embalmer No. 4600

P. O. Address 4648 St. Ferdinand  
St. Louis 13, 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.