

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**=63-022168**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5672** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

1

2 **223**

3

4 **0**

5 **0**

6

7 **0**

8 **1**

9

10

11

12 **91-3**

13

**91**

USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED  
INSTEAD OF  
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
SHOULD READ

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

<b>FILED JUN 13 1963</b>	
1. PLACE OF DEATH a. COUNTY	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>E/R to City Hosp.</b>	
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> ; COUNTY	
c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS <b>2819 Eads</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>KENNETH LeRoy ROSE</b>	
4. DATE OF DEATH Month Day Year <b>May 27, 1963</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>
7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1/11/32</b>
9. AGE (last birthday) <b>31</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>	
11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Curtis Rose</b>	
13b. MOTHER'S MAIDEN NAME <b>Eathel Benson</b>	
14. NAME OF HUSBAND OR WIFE <b>None.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of servt) <b>Yes Korean</b>	
16. SOCIAL SECURITY NO.	
17. INFORMANT Address <b>Eathel Greer, RFD, Lutesville, 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>Cerebral Vascular Accident</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Subdural Hemorrhage (non-traumatic)</b> DUE TO (c) <b>33/X</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	
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 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 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 _____ to _____ and last saw her/him alive on _____ Death occurred at <b>1052 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <b>Paul J. Simon Deputy Coroner</b>	
22b. ADDRESS <b>1300 Clark</b>	
22c. DATE SIGNED (State) <b>5/29/63</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	
23b. DATE <b>5/31/63</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope</b>	
23d. LOCATION (City, town, or county) <b>St. Louis Co., Mo.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>McLaughlin, 2301 Lafayette St. Louis, Mo.</b>	
25. DATE RECD. BY LOCAL REG. <b>MAY 29 1963</b>	
26. REGISTRAR'S SIGNATURE <b>Paul Smith, M.D.</b>	

STATEMENT BY LICENSED EMBALMER

**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

*James R. Chapman*

Licensed Embalmer No. *4557*

P. O. Address *H. Laine, Inc.*

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.