

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-033973

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 316 Primary Registration District No. _____ Registrar's No. 370

FILED OCT 3 1961

1. PLACE OF DEATH a. COUNTY ST FRANCOIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST FRANCOIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN FARMINGTON - RURAL ST. FRANCOIS TWP.		c. CITY OR TOWN FARMINGTON	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION THOMAS DELL HOME		d. STREET ADDRESS (If outside, give location) RFD #1	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last GEORGE W ROSENER			4. DATE OF DEATH Month Day Year SEPT. 25 1961			
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/17/80	9. AGE (last birthday) 81	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	10b. KIND OF BUSINESS OR INDUSTRY FARMING	11. BIRTHPLACE (City and state or country) ST FRANCOIS CO. MO.	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME VALENTINE ROSENER	13b. MOTHER'S MAIDEN NAME SUSAN A COTTONER	14. NAME OF HUSBAND OR WIFE CYNTHIA ELDERS ROSENER	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. 498-34-0312	17. INFORMANT PETER A ROSENER FARMINGTON MO.	Address
---	---	--	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 3 yrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Senility	
	DUE TO (c)	
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 Farmington, Mo	COUNTY ST FRANCOIS	STATE MO.
--	--	---	------------------------------	---------------------

21. I attended the deceased from **1956** to **Sept 25, 1961** and last saw him alive on **Sept 25, 1961**
Death occurred at **9 A** on the date stated above, and to the best of my knowledge from the causes stated.

22a. SIGNATURE R. A. Huckstep M.D.	(Degree or title)	22b. ADDRESS Farmington, Mo	22c. DATE SIGNED 9/26/61
--	-------------------	---------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE Sept. 28, 61	23c. NAME OF CEMETERY OR CREMATORY MARVIN CHAPEL	23d. LOCATION (City, town, or county) (State) NEAR BONNE TERRE MO.
--	----------------------------------	--	--

24. FUNERAL DIRECTOR C. H. COZEAN FARMINGTON MO.	ADDRESS	25. DATE RECD. BY LOCAL REG. Sept. 26, 1961	26. REGISTRAR'S SIGNATURE Ether Rudloff
--	---------	---	---

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF
 ITEM NO.

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 _____

C. H. Hogan
Licensed Embalmer No. 4084
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.