

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39721

FILED JAN 3 1944 318

State File No. 11471
Registrar's No.

Registration District No. Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: DePaul Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Rose M. Dorsey

3. (b) If veteran, name war No. 3. (c) Social Security No. No.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Widow
6. (b) Name of husband or wife Frank H. Dorsey 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 10/28/72
(Month) (Day) (Year)

8. AGE: Years 71 Months 1 Days 21 If less than one day hr. _____ min.

9. Birthplace St. Louis
(City, town, or county) (State or foreign country)

10. Usual occupation Not employed

11. Industry or business _____

MOTHER FATHER { 12. Name Theodore Meyer
13. Birthplace Germany 4
(City, town, or county) (State or foreign country)
14. Maiden name Habetta Krieger
15. Birthplace Germany 4
(City, town, or county) (State or foreign country)

16. (a) Informant Jacob Meyer
(b) Address 6525 San Bonita Ave.

17. (a) Cremation (b) Date thereof 12/21/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Cemetery

18. (a) Signature of funeral director Robert J. Ambruster

(b) Address Clayton Rd. at Concordia Lane

19. (a) DEC 21 1943 (b) J. F. Mudeck
(Date received local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis 96
(c) City or town Clayton 3
(If outside city or town limits, write "RURAL")
(d) Street No. 6625 Clayton Rd. NR
(If rural, give location)
(e) Citizen of foreign country? / (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 19
year 1943 hour 3 minute 45 P. M.

21. I hereby certify that I attended the deceased from 12/18/43 19 to 12/19/43 19
that I last saw her alive on 12/19/43 19
and that death occurred on the date and hour stated above.
Immediate cause of death _____ Duration _____

Cerebral hemorrhage

Due to _____

Due to _____

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

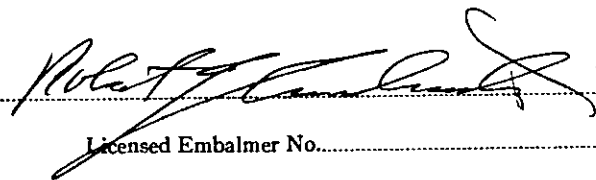
While at work? (Specify type of place) (e) Means of injury _____

23. Signature Henry E. Westerman M.D.
Address 2136 E. Grand Blvd Date signed 12/21/43

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....



Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, fact should be so stated above.