

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

**1. PLACE OF DEATH**

County.....

Registration District No.....

701

1003

Township.....

Primary Registration District No.....

File No.....

16547

Registered No.....

4649

City St. Louis Mo (No. 4550 Natural Bridge St. .... Ward)

**2. FULL NAME**

(a) Residence No. 4550 Natl Bridge St., 10 Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

Male

**4. COLOR OR RACE**

White

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**

Single

**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF**

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)**

June 20 26

**7. AGE**

YEARS 2

MONTHS 10

DAYS

If LESS than 1 day, ..... hrs. or ..... min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY)

St. Louis Mo

**10. NAME OF FATHER**

Lawrence Roach

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

St. Louis Mo

**12. MAIDEN NAME OF MOTHER**

Lottie Becker

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

St. Louis Mo

**14. INFORMANT**

(Address)

Lawrence Roach  
4550 Natural Bridge

**15. FILED**

APR 22 1929

May C. Stanley  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)**

April 20 29

**17.**

I HEREBY CERTIFY, That I attended deceased from Apr 6 1929, to Apr 20 1929, and that I last saw him alive on Apr 20 1929, and that death occurred, on the date stated above, at 9:55 p. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Pneumonia

17A

(duration) ..... yrs. .... mos. 9 ds.

**CONTRIBUTORY (SECONDARY)**

(duration) ..... yrs. .... mos. .... ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? no DATE OF.....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Paul G. G. G. M. D.

, 19 (Address) 6912 Bantuan

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL**

**DATE OF BURIAL**

Calvary Cemetery

April 23 29

**20. UNDERTAKER**

Strook-Carroll

ADDRESS 7600  
Natural  
Bridge

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important.



**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County.....  
Township.....  
City, St. Louis (No. ....)

Registration District No. 991  
Primary Registration District No. 1003

File No. ....  
Registered No. 4649 (Ward).....

**2. FULL NAME**

Jack F. Roach

(a) Residence. No. .... St., ..... Ward. ....  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED s (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work.....  
(b) General nature of industry, business, or establishment in which employed (or employer).....  
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)  
12. MAIDEN NAME OF MOTHER  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED JUN 23 1929 Max E. Parker REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 20 1929

17. I HEREBY CERTIFY That I attended deceased from 19..... to 19..... that I last saw h..... alive on 19....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Bronchopneumonia  
Primary information given  
me by Dr. C. L. Rogers  
of W. B. Co. 19 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) C. L. Rogers, M. D. (Address)....., 19.....

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL 19.....

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

N. B.—Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain language, so that it may be readily classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-16547