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

Do not use this space.

22391

1. PLACE OF DEATH
County St Charles — Registration District No. 757 — File No.
Township — Primary Registration District No. 3036 — Registered No. 98
City St Charles (No. 815 Lewis St. Ward)

2. FULL NAME Louis Roth
(a) Residence. No. 815 Lewis St., 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): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Oct 3 · 1871

7. AGE: YEARS 57 — MONTHS 8 — DAYS 22 — If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Plasterer
(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 Charles Mo

PARENTS
10. NAME OF FATHER: August Roth
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY):
12. MAIDEN NAME OF MOTHER: Barbara Smith
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY):

14. INFORMANT: Anna Roth
(Address) 815 Lewis St

15. FILED 6/28 1929 Ag. G. Bloebaum REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): June 25 1929

17. I HEREBY CERTIFY, That I attended deceased from May 6, 1929, to June 25, 1929 that I last saw him alive on June 25, 1929, and that death occurred, on the date stated above, at 4.30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of Stomach
44a
(duration) yrs. 1 mos. 20 ds.

CONTRIBUTORY (SECONDARY): Starvation, plus.
(duration) yrs. 1 mos. 20 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH at place of death
DID AN OPERATION PRECEDE DEATH? Yes DATE OF May 27 1929
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Physical Exam & History
(Signed) Will L Freeman, M. D.
June 27 1929 (Address) St Charles Mo

*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: Oak Grove Cemetery — DATE OF BURIAL: June 28 1929

20. UNDERTAKER: H Dallmeyer & Sons 60 — ADDRESS: 800 N 2nd St

N. B.—Every [illegible] stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH [illegible] 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 St. Charles Registration District No. 757 File No.
Township Primary Registration District No. 3036 Registered No. 98
City 1 1 1 (No. St. Ward)

2. FULL NAME Louis Roth
(a) Residence. No. St., 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M	W	M

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)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) No History
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) No History
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED 6/28, 1929 Hy. G. Bloebaum
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 25 1929

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

(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) , M. D.
, 19 (Address)

*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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

16822-5