

AUG. 25 1938

REC'D SEP 9 1938

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

29947  
Do not use this space.

1. PLACE OF DEATH  
 (a) County St. Louis Registration District No. 784  
 (b) Township Clayton Primary Registration District No. 181 Registered No. 1406  
 (c) City Clayton (d) Street No. St. Louis County Hospital St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Frank W. Roth  
 (a) Residence, No. 3838 Waco, Normandy, Mo. St.   
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mae Roth  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 7/8/1904  
 7. AGE YEARS 34 MONTHS 1 DAYS 16 If LESS than 1 day, ..... hrs. or ..... min.  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. W.P.A.  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

FATHER 13. NAME Ed Roth  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

MOTHER 15. MAIDEN NAME ? Weaver  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT wife, Mae Roth  
 (ADDRESS)  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Bellefontaine DATE Aug. 26, 1938  
 19. FUNERAL DIRECTOR Chas. A. Bull  
 (ADDRESS) 4452 Washington Blvd.  
 20. FILED AUG 25 1938 R Meyer M.D. P.H.  
 Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8/24/38 19  
 22. I HEREBY CERTIFY, That I attended deceased from 8/6/38 19to 8/24/38 19  
 I last saw him alive on 8/24/38 19. Death is said to have occurred on the date stated above, at 6:35 P.M.  
 The principal cause of death and related causes of importance were as follows:  
Gall stone in common duct  
Cholecystitis, acute  
 Date of onset 8-4-38  
 Other contributory causes of importance:  
Cholecystitis, chronic  
Cholelithiasis  
 Name of operation Cholecystostomy Date of 8-23-38  
 What test confirmed diagnosis? Was there an autopsy? Yes  
 23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? Date of injury, 19  
 Where did injury occur? (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.  
 Manner of injury  
 Nature of injury  
 24. Was disease or injury in any way related to occupation of deceased?  
 If so, specify  
 (Signed) A. A. Brewer, M. D.  
 (Address) St. Louis Co. Hosp. Clayton, Mo.

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

**STATEMENT BY LICENSED EMBALMER**

I, \_\_\_\_\_, Licensed Embalmer No. \_\_\_\_\_  
hereby certify that the body recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
\_\_\_\_\_ L. E. \_\_\_\_\_  
No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed \_\_\_\_\_  
\_\_\_\_\_  
Licensed Embalmer No. \_\_\_\_\_

**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.)**