DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 8208

Registration District No. 784 — Primary Registration District No. 117 — Registrar's No. 265

1. PLACE OF DEATH:

(a) County: St. Louis

(b) City or town: Webster Groves
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 301 Marshall Ave.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: Nil (Specify whether years, months or days)
In this community:

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: St. L.

(c) City or town: Webster Groves
(If outside city or town limits, write "RURAL")

(d) Street No.: 301 Marshall
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: John W. Roam

3. (b) If veteran, name war:

3. (c) Social Security No.:

4. Sex: M

5. Color or race: W

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife: Francis Roam

6. (c) Age of husband or wife if alive: ____ years

7. Birth date of deceased: Unknown (Month) (Day) (Year)

8. AGE: Years: About 79 | Months | Days | If less than one day: ____ hr. ____ min.

9. Birthplace: Swedesburg, Missouri (City, town, or county) O (State or foreign country)

10. Usual occupation: Track Foreman

11. Industry or business: Frisco R. R.

FATHER
12. Name: Unknown
13. Birthplace: Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature: Jack Roam
(b) Address: 7454 Flora

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2-8-1940 (Month) (Day) (Year)
(c) Place: burial or cremation: Mt. Lebannon Cem.

18. (a) Signature of funeral director: [illegible]
(b) Address: 7456 Manchester

19. (a) FEB 7 - 1940 (Date received local registrar) (b) T R Meyer M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Feb. day: 4 year: 1940 hour: 8 1 minute: 30 A.M. P.M.

21. I hereby certify that I attended the deceased from ____, 19____, to ____, 19____; that I last saw h____ alive on ____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Hemorrhagic Pancreatitis — Duration

Due to:

Due to: 1 2 8

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? (Specify type of place)
While at work? no (e) Means of injury:

23. Signature: John O'Connell (M. D. or other)
Address: Coroner of St. Louis Co. Date signed: 2/7/40

(Licensed Embalmer's Statement on Reverse Side)

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.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 H. C. Burgess

Licensed Embalmer No. 4029

P. O. Address Maplewood

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, above space should be left blank.