

Registration District No. 791

Primary Registration District No. 1003

State File No. _____
Registrar's No. 4709

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution: St. Paul 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) 3:00 (ROTH)

3. (a) PRINT FULL NAME Harry John Roth

3. (b) If veteran, name war. no 3. (c) Social Security No. 494-10-0534

4. Sex male 5. Color or race wh 6. (b) Single, widowed, married, divorced married

7. (d) Name of husband or wife Mina Roth 8. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased January 23, 1881
(Month) (Day) (Year)

8. AGE: Years 59 Months 4 Days 3
If less than one day _____ hr. _____ min.

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

10. Usual occupation Division Sales Manager

11. Industry or business Ely Walker Dry Goods

12. Name Henry Roth
13. Birthplace Alsace Lorraine
14. Maiden name Wardou Baba Serd
15. Birthplace Alsace Lorraine
(City, town, or county) (State or foreign country)

16. (a) Informant Mina Roth
(b) Address 5337 Delmar

17. (a) Burial (b) Date thereof May 29, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Bellefontaine Cem.

18. (a) Signature of funeral director Chas. F. Stuart
(b) Address 1225 Main Blvd.

19. (a) MAY 28 1940 (b) J. B. Brubaker
(Date received in office) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
(c) City or town St. Louis 12
(If outside city or town limits, write "RURAL")
(d) Street No. 5337 Delmar
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 26
year 1940 hour 11:30 minute AM

21. I hereby certify that I attended the deceased from 5-21-40
_____ 19____, to 5-26 1940

that I last saw him alive on 5-26-40 19____
and that death occurred on the date and hour stated above.

Immediate cause of death acute decompensated cardiac
Duration _____

Due to chr. myo cardiac

Due to fall on 5-19-40
(No apparent injuries)

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations no Of autopsy no
930

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 Eugene J. Whalley (M. D. or other) MD
Address unpublished Date signed 5-27-40

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

Bernard G. Stuard

Licensed Embalmer No.

3500

P. O. Address

1225 Union Bl

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.