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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 23220

AUG 25 1940

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 5665

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

1. PLACE OF DEATH:

(a) County: St. Louis

(b) City or town: St. Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Ann's Hospital
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

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

(c) City or town: St. Louis Missouri
(If outside city or town limits write "RURAL")

(d) Street No.: 5301 Page Blvd.
(If rural, give location)

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

3. (a) PRINT FULL NAME: Marie Catherine Roth

3. (b) If veteran, name war: ____

3. (c) Social Security No.: ____

4. Sex: F

5. Color or race: W

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

6. (b) Name of husband or wife: ____

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

7. Birth date of deceased: June (Month) 29 (Day) 1940 (Year)

8. AGE: Years ____ Months ____ Days 4 If less than one day ____ hr. ____ min.

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

10. Usual occupation: ____

11. Industry or business: ____

MOTHER FATHER

12. Name: unknown

13. Birthplace: unknown (City, town, or county) (State or foreign country)

14. Maiden name: Loretta Roth

15. Birthplace: Carrollton (City, town, or county) Illinois (State or foreign country)

16. (a) Informant: ~~St. Ann's Hospital~~ Sister Bernadette

(b) Address: 5301 Page Blvd.

17. (a) Calvery (Burial, cremation, or removal) (b) Date thereof: July (Month) 3 (Day) 1940 (Year)

(c) Place: burial or cremation: Calvery

18. (a) Signature of funeral director: Theodore Mohr

(b) Address: 5301 Page Blvd.

19. (a) JUL 3 1940 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 3 year 1940 hour 5 minute 15 A. M.

21. I hereby certify that I attended the deceased from June June 29, 1940 to July 3, 1940 that I last saw him alive on July 2, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Congenital Atelectasis	
Due to: Pre Maturity	
Due to:	
Other conditions (Include pregnancy within 3 months of death): None	

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? ____ (e) Means of injury: ____

23. Signature: John B. Orwell (M. D. or other)

Address: 1222 Missouri Theater Date signed 7/2/40

(Licensed Embalmer's Statement on Reverse Side)

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.....

, Licensed Embalmer No.....

P. O. Address.....

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.