

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED DEC 10 1942

Registration District No. _____

Primary Registration District No. 101

Registrar's No. 2367

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

1. PLACE OF DEATH:

(a) County ST. LOUIS
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ST. LOUIS COUNTY HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 DAYS
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
(c) City or town Helton
(If outside city or town limits, write "RURAL")
(d) Street No. 6722 ROBERTS AVE
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MAMIE S. ROYER

3. (b) If veteran, name war NONE 3. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife JOSEPH S. ROYER 6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased FEB - 13 - 1878
(Month) (Day) (Year)

8. AGE: Years 64 Months 8 Days 28 If less than one day _____ hr. _____ min.

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

10. Usual occupation HOUSE WIFE

11. Industry or business HOME

12. Name NEAL MARTIN

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

14. Maiden name UNKNOWN

15. Birthplace UNKNOWN (City, town, or county) (State or foreign country)

16. (a) Informant Joseph Shroppe

(b) Address 6722 Roberts

17. (a) BURIAL (b) Date thereof 11-13-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Lebanon

18. (a) Signature of funeral director Gullen & Kelly

(b) Address 7267 Mail Bldg

19. (a) NOV 11 1942 (b) C. D. McEwan
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 10 year 42 hour 7 minute PM M.

21. I hereby certify that I attended the deceased from 11-6-42 1942 to 11-10 1942

that I last saw her alive on 11-10- 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral injury left side brain Duration 8 hrs.

Due to hypertrophy & dil. of heart congestion & edema of lungs

Due to DRUG POISON 952

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

Major findings: Kidney perforation Of operations _____

Of autopsy retroperitoneal abscess & dil. of heart long perforation & edema of lungs Underline the cause to which death should be charged etiologically.

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 C. D. McEwan (M. D. or other) _____
Address St. Louis, Mo Date signed 11/11/42

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 Clement McMay
Licensed Embalmer No. 3732
P. O. Address St. Louis

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, fact should be so stated above.

CRAT 11 10/11