

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH  
1003

700

State File No.

683

Registration District No. 318

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
3160 Nebraska Ave. /  
(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. (a) PRINT FULL NAME Joseph W. Romacker

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Laura Romacker 6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased September 7, 1878  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
64 4 15 hr. min.

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

10. Usual occupation Printer

11. Industry or business

12. Name Bernard Romacker 13. Birthplace Germany  
(City, town, or county) (State or foreign country)

14. Maiden name Inbresa Redding  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. Laura Romacker  
(b) Address 3160 Nebraska Ave.

17. (a) Burial (b) Date thereof Jan. 26/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peter's Cemetery

18. (a) Signature of funeral director Weick Bros. Und. Co.  
(b) Address 2201 S. Grand Bl.

19. (a) JAN 23 1943 (b) J. F. Braden  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3160 Nebraska Ave.  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 22  
year 1943 hour 3 minute 30 A.M.

21. I hereby certify that I attended the deceased from Jan 20, 1943, to Jan 22, 1943, that I last saw him alive on Jan 22, 1943, and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy  
Cerebral Hemorrhage

Due to.....  
Due to Arterio Sclerosis !

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

Major findings:  
Of operations.....

Of autopsy.....

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 Henry P. Graul (M. D. or other) MD  
Address 2905 Cherokee St. Date signed 1/22/43

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

MOTHER FATHER

*Dr. Howard  
2905 - Cherokee*

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**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..... *Henry A. Stewart* .....

Licensed Embalmer No. 3722.....

P. O. Address. 412 Duchouquette St......

**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.**