

Registration District No. **784** Primary Registration District No. **101**

1. PLACE OF DEATH:
(a) County **St. Louis**
(b) City or town **Clayton**
(c) Name of hospital or institution: **St. Louis County Hospital**
(d) Length of stay: **12 days**
In this community **12 days**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **St. Louis**
(c) City or town **Lemay**
(d) Street No. **3712 Cleves Ave.**
(e) Citizen of foreign country? **no**

3. (a) PRINT FULL NAME **Rudolph Roth**
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 **Anna Kessels Roth** 6. (c) Age of husband or wife if alive **48** years
7. Birth date of deceased **July 1 1878**

8. AGE: Year **64** Months **6** Days **27** If less than one day hr. **5** min.

9. Birthplace **Unknown Switzerland**

10. Usual occupation **carpenter**
11. Industry or business **unemployed**

MOTHER FATHER { 12. Name **John Roth**
13. Birthplace **Hamburg Switzerland**
14. Maiden name **Mary Brunner**
15. Birthplace **Hamburg Switzerland**

16. (a) Informant **Mrs. Mary Roth**
(b) Address **3712 Cleves**
17. (a) **burial** (b) Date thereof **2-1-43**
(c) Place: burial or cremation **Mt. Hope**
18. (a) Signature of funeral director **Ferdinand Hundt**
(b) Address **7420 Michigan**
19. (a) **FEB 1 1943** (b) **C. D. McFarson**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Jan.** day **28**
year **1943** hour **8** minute **:20** p.m.

21. I hereby certify that I attended the deceased from **1-16-43**
to **1-28-43**
that I last saw him alive on **1-28-43**

and that death occurred on the date and hour stated above.
Immediate cause of death **cardiac failure** Duration **5 min.**

Due to **cardiac decompensation with auricular fibrillation** **9 WKS**
Due to **arteriosclerotic heart disease** **10 YRS.**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **93A**
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?
(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
Signature **Robert A. Hall** (M. D. or other) **M. D.**
Address **St. Louis County Hosp.** Date signed **1-29-43**

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

16
32

96
0

Duration
5 min.

9 WKS

10 YRS.

PHYSICIAN

Underline the cause to which death should be charged statistically.

M. D.

1-29-43

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.....

Oliver C. Struble

Licensed Embalmer No. *7148*

P. O. Address, *St. Louis, Mo.*

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.