S. No. 2
M—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

8185

FILED APR 13 1945 818

State File No.

Registration District No. Primary Registration District No. 1003

Registrar's No. 2982

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: 1900 Hickory Str. (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)

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. 1900 Hickory Str. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Mike Romero

3. (b) If veteran, name war ----

3. (c) Social Security No. 709-09-2594

4. Sex Male

5. Color or race Wht.

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Gaudalupe Romero

6. (c) Age of husband or wife if alive 35 years

7. Birth date of deceased Unknown (Month) About (Day) 1887 (Year)

8. AGE: Years About 58 Months Unknown Days If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business Pullman Co.

FATHER
12. Name Jacob Romero
13. Birthplace (City, town, or county) Mexico (State or foreign country)

MOTHER
14. Maiden name Rose ?
15. Birthplace (City, town, or county) Mexico (State or foreign country)

16. (a) Informant Gaudalupe Romero
(b) Address 1900 Hickory Str.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4/45 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Wm. C. Mogdell
(b) Address 1926 Allen Ave.

19. (a) APR 4 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 1 year 1945 hour 8 minute A. M.

21. I hereby certify that I attended the deceased from 3-1-45, 19, to 4-1-45, 19; that I last saw him alive on 3-31-45, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis

Due to Lost K Knowy

Due to 93

Other conditions none (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

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)

(e) Means of injury

23. Signature Walter H. Spoeneman M.D. (M.D. or other)

Address 1506 St Louis Date signed 4-3-45

(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 me

, Registered Apprentice No.

working under my personal supervision.

Signed D. M. Davis

Licensed Embalmer No. 3741

P. O. Address 1926 Allen

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.