

S. No. 2
M-2-43
5-17-39
PI X35637

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11694
Registrar's No. 3515

FILED MAY 12 1945
318
Registration District No. _____

Primary Registration District No. 1003

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

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: DE PAUL HOSPITAL
(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 MO (b) County ST LOUIS
(c) City or town ST LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 2827 BIRD AVE
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME PATRICIA ROACH
(b) If veteran, name war NO (c) Social Security No. NO

20. DATE OF DEATH: Month April day 20th
year 1945 hour 4 minute 15 a. M.

4. Sex FEMALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced SINGLE
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____
allive _____ years

21. I hereby certify that I attended the deceased from April 6, 1945, to April 20, 1945;
that I last saw him alive on April 19, 1945;
and that death occurred on the date and hour stated above.

7. Birth date of deceased MARCH 29 1945
(Month) (Day) (Year)

Immediate cause of death: Gastric Enteritis of New Bow Duration 2 weeks

8. AGE: Years Months Days If less than one day
0 0 22 hr. _____ min.

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

9. Birthplace ST LOUIS MO
(City, town, or county) (State or foreign country)

10. Usual occupation NONE

11. Industry or business _____

Major findings: _____
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER { 12. Name JEROME ROACH
13. Birthplace JEFFERSON CITY MO
(City, town, or county) (State or foreign country)
14. Maiden name MARCELLA PALMIER
15. Birthplace PRAIRIE du ROCHER ILL
(City, town, or county) (State or foreign country)

16. (a) Informant Sister Anne
(b) Address De Paul Hospital

17. (a) REMOVAL (b) Date thereof 4-20-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation PRAIRIE du ROCHER ILL

18. (a) Signature of funeral director Cullen Kelly
(b) Address 4386 LINDELL BLVD.

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? _____

19. (a) APR 20 1945 (b) J. J. Brudack
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) (c) Means of injury _____
23. Signature Kell h Cook md (M. D. or other) _____
Address 508 N. Grand Date signed 4-20-45

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 *James A. Lammers*
Licensed Embalmer No. *4142*
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.