

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Deaconess Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 weeks
(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 Union City (If outside city or town limits, write "RURAL")
(d) Street No. 1109 North + South Rd.
(If rural, give location) INR.
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME

Mary Roth

(b) If veteran, name war _____

(c) Social Security No. None

4. Sex F 5. Color or race A. 6. (a) Single, widowed, married, divorced M.

6. (b) Name of husband or wife Henry 6. (c) Age of husband or wife if alive 81 years

7. Birth date of deceased Aug. 27 - 1869
(Month) (Day) (Year)

8. AGE: Years 75 Months 8 Days 16
If less than one day _____ hr. _____ min.

9. Birthplace Franklin Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business _____

12. Name Joseph Neier

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

14. Maiden name Katherine

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

16. (a) Informant Henry Roth

(b) Address 1109 North + South Rd.

17. (a) Burial (b) Date thereof 5/15/1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Central Cemetery - Clayton

18. (a) Signature of funeral director Louis H. Bopp, Inc.

(b) Address Foranite + Healy (Clayton Mo.)

19. (a) MAY 15 1945 (b) J. F. Probeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 12
year 1945 hour 11 minute 35 A. M.

21. I hereby certify that I attended the deceased from 7/12/45
19____ to 5/12/45 19____
that I last saw h. ✓ alive on 5/11/45 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary arteriosclerosis

Due to _____
Due to 97
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 J. F. Probeck (M. D. or other)
Address 634 N. Grand Date signed 5/15/45

Duration _____
years.
PHYSICIAN
+
Underline the cause to which death should be charged statistically.

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

4282

4282

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 *Felix Durand*

Licensed Embalmer No. *3034*

P. O. Address *Kirkwood 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, above space should be left blank.