

FILED JUL 11 1945

Registration District No. 274Primary Registration District No. 3052Registrar's No. 152

## 1. PLACE OF DEATH:

(a) County Pettis  
 (b) City or town Sedalia  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Bothwell Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 3 days  
 In this community 3 days years (Specify whether  
 years, months or days)

3. (a) PRINT  
FULL NAMEEdna Mae Du Roche3. (b) If veteran,  
name war3. (c) Social Security  
No.4. Sex F5. Color or  
race W6. (a) Single, widowed, married,  
divorced married6. (b) Name of husband or wife  
Robert Edward Du Roche6. (c) Age of husband or wife if  
alive 63 years7. Birth date of deceased Feb. 24 1891  
(Month) (Day) (Year)

## 8. AGE:

Years

Months

Days

If less than one day

54314

hr.

min.

9. Birthplace

Yuma County

(City, town, or county)

Colorado

(State or foreign country)

10. Usual occupation

housewife

11. Industry or business

12. Name Albert Hollingshead

13. Birthplace

Ohio

(City, town, or county)

(State or foreign country)

14. Maiden name

Katherine Windell

15. Birthplace

Illinois

(City, town, or county)

(State or foreign country)

16. (a) Informant

Robert Edward Du Roche

(b) Address

Versailles, Missouri17. (a) burial

(b) Date thereof

6 10 45  
(Month) (Day) (Year)(c) Place: burial or cremation Glensted Cemetery

18. (a) Signature of funeral director

(b) Address

19. (a) 6-13-45(b) Mrs Anna Berger

(Date received local registrar)

(Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Morgan  
 (c) City or town Rural Versailles  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
 (If rural, give location)  
 (e) Citizen of foreign country?  (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 8  
 year 1945 hour 1 minute 5 P.M.

21. I hereby certify that I attended the deceased from

June 5, 1945, to June 8, 1945,  
 that I last saw her alive on June 8, 1945,  
 and that death occurred on the date and hour stated above.

Immediate cause of death fracture of  
seventh cervical and  
first dorsal vertebral  
 Due to both clavicles right  
pleura rupture right  
 Due to kidney due to and  
automobile accident

Duration

Other conditions  
 (Include pregnancy within 3 months of death)

Major findings:  
 Of operations

Of autopsy

PHYSICIAN

Underline  
 the cause to  
 which death  
 should be  
 charged sta-  
 tistically.

STATISTICAL  
 INFORMATION  
 REQUESTED

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident  
 (b) Date of occurrence June 5 - 45  
 (c) Where did injury occur? Highway 5 Morgan, Mo.  
 (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Highway

While at work? no

(Specify type of place)

(e) Means of injury Automobile  
accident23. Signature M. P. Stief

(M. D. or other)

Address Sedalia MoDate signed 6-11-45

1032

RECEIVED

District Health Officer No. 6

District File Number

Date Filed

7/9/45

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

*J. F. Kimmel*

Licensed Embalmer No.

1596

P. O. Address

*Wesley 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. July 1972Registration District No. 274Primary Registration District No. 3052

Registrar's No. \_\_\_\_\_

## 1. PLACE OF DEATH

(a) County Butte  
 (b) City or town Sedalia  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
 (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

Edna Mae DeRoche

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased Feb 24 1902  
(Month) (Day) (Year)8. AGE: Years 54 Months 3 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.9. Birthplace Colorado  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

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

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day \_\_\_\_\_  
Year 1972 Hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to I do not know. Someone said it was truck. it could have been  
 Other condition \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings:

Of operations \_\_\_\_\_

Of autopsy 70c 8 17 72

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 in her bath23. Signature m o Shy (M. D. or other) \_\_\_\_\_Address \_\_\_\_\_ Date signed 7-12-72

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

SUPPLEMENTARY

ADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
REQUESTED

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

21006