

S. No. 2
M-8-43
v. 5-17-39
P. I. X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22494
State File No. _____
Registrar's No. 6018

FILED JUL 20 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:
Lutheran Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Day
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis 96
(c) City or town Lemay 18
(If outside city or town limits, write "RURAL")
(d) Street No. None
(If rural, give location) NR.
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Louis F. Romer

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 9th day July
year 1945 hour 11:45 minute P. M.

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

21. I hereby certify that I attended the deceased from Jan 14
1945 to July 9 1945
that I last saw him live on July 9
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, Married

Immediate cause of death Acute Cardiac Failure
Duration 20 Min

6. (b) Name of husband or wife Margaret Romer 6. (c) Age of husband or wife if alive 55 years

Due to Chronic Myocarditis ?

7. Birth date of deceased August 16 1888
(Month) (Day) (Year)

Due to Valvular Insufficiency Mild

8. AGE:	Years	Months	Days	If less than one day
	<u>56</u>	<u>10</u>	<u>23</u>	hr. _____ min. _____

Other conditions Chronic Rheumatism ?
(Include pregnancy within 3 months of death)

9. Birthplace Missouri (City, town, or county) _____ (State or foreign country) 0

PHYSICIAN
Major findings: _____
Of operations: 1/24
Of autopsy: _____
Underline the cause to which death should be charged statistically.

10. Usual occupation Chauffeur

11. Industry or business Anheuser-Busch Inc

12. Name William Romer

13. Birthplace Missouri (City, town, or county) _____ (State or foreign country) 0

14. Maiden name Katherine Weber

15. Birthplace Missouri (City, town, or county) _____ (State or foreign country) 0

16. (a) Informant Margaret Romer
(b) Address Lemay Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 12 1945
(Month) (Day) (Year)

(c) Place: burial or cremation Sunset Burial Park

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 0

23. Signature J. P. Crease (M. D. or other) _____
Address 3805 S. Broadway Date signed 7/10/45

No. 3
7 to 8

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 Rex E. Campbell
Licensed Embalmer No. 3881
P. O. Address St. James, 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.