V. S. No. 2
100M—5-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35800

FILED DEC 18 1945

Registration District No. 1003 Primary Registration District No. 1003 Registrar's No. 10272

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: Park Lane 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 Missouri (b) County

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 929a Goodfellow
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Frances Rollade Roach

3. (b) If veteran, name war Nil

3. (c) Social Security No. Unknown

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Joseph Roach

6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased July (Month) 10 (Day) 1896 (Year)

8. AGE: Years 49 Months 4 Days 16 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Elon Eldred
13. Birthplace Carrollton (City, town, or county) Illinois (State or foreign country)

MOTHER
14. Maiden name Nina Cooper
15. Birthplace Unknown (City, town, or county) Minnesota (State or foreign country)

16. (a) Informant Joseph Roach
(b) Address 929a Goodfellow Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-29-45 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) NOV 27 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 26 year 1945 hour 9:25 minute P. M.

21. I hereby certify that I attended the deceased from Sept. 1, 1945 to Nov 26, 1945 that I last saw her alive on Nov 26, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Broncho-Pneumonia — Duration 3 days

Due to Flu

Due to

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 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)

While at work? (e) Means of injury

23. Signature T. J. Kemp (M. D. or other)

Address 4503 Washington Date signed 4/27/45

(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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed. Elmer R. Padwell

Licensed Embalmer No. 4077

P. O. Address.....

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.