

S. No. 2  
OM-5-43  
v. 5-17-39  
I X36571

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
NOV 17 1945  
STANDARD CERTIFICATE OF DEATH

38598

State File No. 0  
Registrar's No. 2578

Registration District No. 317 Primary Registration District No. 6076

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

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Halls Ferry Memorial Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6 weeks  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County 000  
(c) City or town St Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3823 Juniata  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Emily Roeder  
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 S 0  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased August 6 1869  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
76 3 2 hr. min.

9. Birthplace St Louis Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business \_\_\_\_\_  
12. Name Michael Roeder  
13. Birthplace Germany  
(City, town, or county) (State or foreign country)  
14. Maiden name Anna Mary Steffen  
15. Birthplace Germany  
(City, town, or county) (State or foreign country)

MOTHER FATHER

16. (a) Informant Charlotte Roos  
(b) Address 6345 Tholozan (1945)  
17. (a) Burial (b) Date thereof November 10  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Bellefontaine Cem

18. (a) Signature of funeral director Beiderwieden F H Inc  
(b) Address 1936 St Louis Avenue

19. (a) 11-10-45 (b) E. J. McDonald  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Nov day 8 year 1945 hour 9:30 minute A M.  
21. I hereby certify that I attended the deceased from Sept 25 to Nov 8 1945  
that I last saw h. u alive on Nov 7 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Cornary occlusions  
Due to Endocarditis  
Due to 93d  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Duration

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_  
23. Signature M. Shaver (M. D. or other)  
Address Emell Trust Bldg Date signed 11-8-45

**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 *Felix J. Krispin*  
Licensed Embalmer No. *3497*  
P. O. Address *1936 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.