

THE STATE BOARD OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH  
 1003

State File No. **39714**  
 Registrar's No. **10923**

**FILED DEC 28 1945**  
 Registration District No. **318**

Primary Registration District No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County St. Louis  
 (b) City or town St. Louis  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 822a Angelica St  
 (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 St. Louis  
 (c) City or town St. Louis  
 (If outside city or town limits, write "RURAL" and name of township)  
 (d) Street No. 822a Angelica St.  
 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mrs. Margaret Roesch

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced widowed

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

7. Birth date of deceased Nov. 6, 1869  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>1</u>	<u>7</u>	hr. _____ min. _____

9. Birthplace Mineral Point Mo.  
 (City, town, or county) (State or foreign country)

10. Usual occupation none

MOTHER FATHER

11. Industry or business unknown

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant Herman Runde

(b) Address 823a Wright St.

17. (a) Burial (b) Date thereof 12-15-45  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Friedens Cemetery

18. (a) Signature of funeral director H. Leidner U. Co.

(b) Address 2223 St. Louis Ave.

19. (a) DEC 15 1945 (Date received local registrar)  
J. F. Brundick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 13th.  
 year 1945 hour 4:00 AM minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 1941, 19\_\_\_\_, to December 11, 1945  
 that I last saw h. er alive on December 11, 1945  
 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
1) Broncho pneumonia 2 weeks  
2) Arteriosclerosis indefinite  
3) Nephritis, Chronic

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) 131

Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_

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 \_\_\_\_\_  
 Signature John S. Young (M. D. or other)  
 Address 1126 St. Louis Avenue Date signed 12/14/45

**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 *John P. Buchholz*  
Licensed Embalmer No. *1674*  
P. O. Address. *2223 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.**