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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 39718

FILED JAN 11 1946

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11531

1. PLACE OF DEATH:

(a) County St. Louis, Mo.

(b) City or town (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Barnes 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) 34 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois 94

(c) City or town Bonne Terre (If outside city or town limits, write "RURAL")

(d) Street No. 213 Summit St. (If rural, give location) NR

(e) Citizen of foreign country? 1 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME BARBARA ~~Rokan~~ ROKAN

3. (b) If veteran, name war Nil

3. (c) Social Security No. None

4. Sex Female 1

5. Color or race White

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

6. (b) Name of husband or wife Christ Rokan

6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased June (Month) 25 (Day) 1889 (Year)

8. AGE:

Years	Months	Days	If less than one day
56	6	2	hr. min.

9. Birthplace Unknown (City, town, or county) Czecho-Slovakia (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name George Gallie
13. Birthplace Czecho-Slovakia (City, town, or county) (State or foreign country)

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

16. (a) Informant Christ Rokan

(b) Address Bonne Terre, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-45 (Month) (Day) (Year)

(c) Place: burial or cremation Bonne Terre, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) DEC 28 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 27 year 1945 hour 9 minute 45 A.M.

21. I hereby certify that I attended the deceased from 11-23, 1945, to 12-27, 1945 that I last saw her alive on 12-27, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cardiac failure	
Due to Myocardial infarction	5 wks.
Due to Arteriosclerotic Heart Disease	
Other conditions (Include pregnancy within 3 months of death) Diabetes mellitus - arterial occlusion c̄ dry gangrene left foot -	
Major findings: Of operations	
Of autopsy Myocardial infarct - general arteriosclerosis - nephrosclerosis - infarct of lung	

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 F. R. Bradley (M. D. or other)

Address Barnes Hospital Date signed

(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 G. W. Wilkinson

Licensed Embalmer No. 3575

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.