

FILED JUN 11 1946

Registration District No. **316**

Primary Registration District No. **3061**

1. PLACE OF DEATH

(a) County **St. Francois**
(b) City or town **Flat River, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1**
(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)

3. (a) PRINT FULL NAME **Mrs. Mary Roark**
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex **Female** 5. Color or ~~white~~ race **Cauc.**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Burgie Roark**
6. (c) Age of husband or wife if alive **52** years
7. Birth date of deceased **Dec 5 1902**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
43 4 19 hr. min.

9. Birthplace **Pennsylvania**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____
12. Name **Mr. Joe Zarowski** #
13. Birthplace **Poland**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary Green**
15. Birthplace **Poland** #
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Burgie Roark**
(b) Address **Flat River, Mo.**
17. (a) **Burial** (b) Date thereof **May 6-1946**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **St. Francois M. Church, Burial**

18. (a) Signature of funeral director **Alvin W. Hood**
(b) Address **303 Crane St. Flat River, Mo.**
19. (a) **5-17-46** (b) **Cather Rudloff**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **St. Francois** **94**
(c) City or town **Flat River, Mo.** **5**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) **2**
(e) Citizen of foreign country? **No** (Yes or No) **0**
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MAY** day **FOURTH**
year **1946** hour **ONE** minute **TEN P.M.**
21. I hereby certify that I attended the deceased from **JULY** 19**44** to **MAY 4** 19**46**;
that I last saw h. **E.N.** alive on **MAY 3** 19**46**;
and that death occurred on the date and hour stated above.

Immediate cause of death **CEREBRAL HEMORRHAGE** **2 DAYS**
Due to **CARDIO-RENAL-VASCULAR DISEASE** **9 YEARS**

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: **13/2**
Of operations _____
Of autopsy _____

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)
(c) Means of injury _____
23. Signature **M.A. Ralley** (M.D. or other) **2**
Address **Flat River, Mo.** Date signed **5/6/46**

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

16735

RECEIVED

District Health Officer No. 4
District File Number 646-223
Date Filed 6-10-46

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 Alvin W. Hood

Licensed Embalmer No. 2780

P. O. Address Flat River, 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.