. No. 2
—1/47
5-17-39

WHITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED MAY 22 1947

MISSOURI DIVISION OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 19292

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4905

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: Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 010
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 1027 a N Pendleton 9
(If rural, give location) 0
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Ollie Roan
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Female 3
5. Color or race Col
6. (a) Single, widowed, married, divorced Divorced
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Unknown (Month) (Day) 1904 (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---|---|---|---|---|
| abt- | 43 | ? | ? | hr. min. |

9. Birthplace Tenn. (City, town, or county) (State or foreign country)
10. Usual occupation Nil
11. Industry or business
FATHER
12. Name John Roan
13. Birthplace Tenn. (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Elizabeth Walker
15. Birthplace Tenn. (City, town, or county) (State or foreign country)
16. (a) Informant Callie Cunningham
(b) Address 1027 Pendleton
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/15th 47 (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park Cem
18. (a) Signature of funeral director Priest + Walker
(b) Address 2829 Washington Blvd
19. (a) MAY 15 1947 (Date received local registrar) (b) J. F. Predeek (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 9 year 1947 hour 8 minute 5 A.M.
21. I hereby certify that I attended the deceased from 5-7, 1947, to 5-9, 1947; that I last saw him alive on May 9, 1947; and that death occurred on the date and hour stated above.

| Immediate cause of death | Duration |
|---|---|
| Amyotrophic Lateral Sclerosis | Undet. |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) Broncho-pneumonia | Undet. |

Major findings:
Of operations
Of autopsy Yes

PHYSICIAN — Underline the cause of 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 Edw B. Williams (M. D. or other)
Address 2601 N Whittier Date signed 5/10/47

Jefferson City Printing Co. (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.....

Licensed Embalmer No. 4441

P. O. Address 2829 Washington

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.