

FILED JUL 21 1947

Registration District No. **318**

Primary Registration District No. **1003**

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:  
3911a Miami Street  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution.....  
 In this community..... life (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME WILLIAM ROMER  
 3. (b) If veteran, name war Nil  
 3. (c) Social Security No. 495-26-9593

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M  
 6. (b) Name of husband or wife Anna 6. (c) Age of husband or wife if alive 49 years  
 7. Birth date of deceased July 30, 1892  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
54 11 14 hr. min.

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

10. Usual occupation Custodian

11. Industry or business St. L. Public Schools

12. Name William Romer

13. Birthplace St. Louis, Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Katie Weber

15. Birthplace St. Louis, Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Anna Romer

(b) Address 3911a Miami Street

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 7-16-47  
(Month) (Day) (Year)

(c) Place: burial or cremation New Florence, Missouri

18. (a) Signature of funeral director A. W. McLaughlin

(b) Address 2301 Lafayette Avenue

19. (a) Jul 16 1947 (Date received local health authority) J. F. Bredes (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County 000  
 (c) City or town St. Louis 17  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 3911a Miami Street 9  
(If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No) 0  
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 14<sup>th</sup>  
 year 1947 hour 11:05 minute 2 M.  
 21. I hereby certify that I attended the deceased from October 5<sup>th</sup>  
 1946, to July 14<sup>th</sup> 1947  
 that I last saw h. in alive on July 14<sup>th</sup> 1947  
 and that death occurred on the date and hour stated above.

Immediate cause of death.....  
Chronic Interstitial Nephritis 2 yrs.  
 Due to Arterio-sclerosis 2 yrs.  
 Due to Hypertension 3 yrs.  
 Other conditions —  
(Include pregnancy within 3 months of death)  
 Major findings: —  
 Of operations —  
 Of autopsy —

Duration  
 2 yrs.  
 2 yrs.  
 3 yrs.  
 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 Albert Berberth (M. D. or other) MD  
 Address 3606 Gravois ave Date signed 7/16-47

Dr. A. Beisbarth  
3606 Gravois Av.

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**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..... *EW Cooper*.....

Licensed Embalmer No. *3830*.....

P. O. Address. *2301 Lafayette*.....

**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.**