

No. 2
-12-45
-17-39
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 43720
Registrar's No. 2544

FILED DEC 22 1947
Registration District No. 3069

Primary Registration District No. 3069

1. PLACE OF DEATH

(a) County St. Louis

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

(c) Name of hospital or institution: St. Mary's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) _____ (Specify whether)

In this community _____ (Specify whether years, months or days) _____

3. (a) PRINT FULL NAME EUGENIA C. ROOS

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Isadore M. Roos 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

About 80 hr. min.

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

10. Usual occupation At home

MOTHER FATHER

11. Industry or business _____

12. Name Leopold Straus

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

14. Maiden name Unknown

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

16. (a) Informant Sister Edith

(b) Address St. Mary's Hospital

17. (a) Burial (b) Date thereof 12-9-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Sinai Cemetery

18. (a) Signature of funeral director William J. ...

(b) Address 5216 Delmar Blvd.

19. (a) 12-8-47 (b) Beulah ...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Richmond Heights
(If outside city or town limits, write "RURAL")

(d) Street No. St. Mary's Hospital
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 7
year 1947 hour 9:00 minute _____ M.

21. I hereby certify that I attended the deceased from 6/1/46
_____ 19 _____ to 12/6/47 19 _____
that I last saw him _____ alive on 12/6/47 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Coronary occlusion

Due to arteriosclerotic coronary thrombosis

Due to 940

Other conditions Arteriosclerotic Aorta
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

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? _____

23. Signature Sallee ... (M. D. or other) _____
Address 3923 ... Date signed _____

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

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 Ketterer*.....
Licensed Embalmer No. *3880*.....
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.