

S. No. 300
M-10-47
v. 5-17-39
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FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED MAR 11 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

6256

State File No.

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **2062**

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

1. PLACE OF DEATH:

(a) County **St. Louis Mo.**
(b) City or town **St. Louis Mo.**
(c) Name of hospital or institution **No. 310 - 20**
(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)

3. (a) PRINT FULL NAME **Roxie Talps**

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

4. Sex **Female** 5. Color of hair **Grey** 6. (a) Single, widowed, married, divorced _____

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

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

8. AGE: Years **at 60** Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____ 9

13. Birthplace _____ (City, town or county) (State or foreign country) 9

14. Maiden name _____ 9

15. Birthplace _____ (City, town or county) (State or foreign country) 9

16. (a) Informant **Special Officer**

(b) Address _____

17. (a) **Anatomical Board** (b) Date thereof **FEB 29 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Anatomical Board**

18. (a) Signature of funeral director **Rowland Mortuary Service**
(b) Address **4104 Manchester Ave.**

19. (a) **FEB 29 1948** (Date received local registrar) **J. F. Brobeck** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **St. Louis**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **2102 Chestnut**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **5** year **1948** hour **9** minute **50** M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Due to **Meningoencephalitis**

Due to **Meningitis**

Other conditions: (include pregnancy within 3 months of death) **St. M. A.**

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? _____

While at work? _____ (Specify type of place) (e) Means of injury **3**

23. Signature **Edward Perry** (M. D. or other) _____
Address _____ Date signed **2/11/48**

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 Ralph W. Henson

Licensed Embalmer No. 3791

P. O. Address St. Louis, 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.