

No. 2
1/47
5-17-39

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **6950**
1606
Registrar's No.

FILED FEB 28 1948

Registration District No. **318** Primary Registration District No. **1003**

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 **Deaconess Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community.....
years, months or days

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. **1330 Highland Terrace**
n.p. (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **George D. Roney**
3. (b) If veteran, name war **No.** 3. (c) Social Security No. **?**
4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married; divorced **Single**
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased **3/13/1915**
(Month) (Day) (Year)
8. AGE: Years Months Days If less than one day
32 11 3 ..hr. ..min.

9. Birthplace **St. Louis** **Mo**
(City, town, or county) (State or foreign country)
10. Usual occupation **Clerk**

11. Industry or business **Post Office**
12. Name **Robert M. Roney**
13. Birthplace **Columbus Ohio**
(City, town, or county) (State or foreign country)
14. Maiden name **Grace M. Dutton**
15. Birthplace **Jarneyville Ill**
(City, town, or county) (State or foreign country)

16. (a) Informant **Robert M. Roney**
(b) Address **1330 Highland Terrace**

17. (a) **Burial** (b) Date thereof **2/18/48**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Laurel Hill Gardens**

18. (a) Signature of funeral director **Robert J. Ambruster Inc**
(b) Address **6633 Clayton Road**

19. (a) **FEB 17 1948** (b) **J. F. Bradeet**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **February** day **16th**
year **1948** hour **5** minute **A** M.
21. I hereby certify that I attended the deceased from **1/25/48**, 19....., to **2/16/48**, 19.....; that I last saw him alive on **2/16/48**, 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial failure**
Due to **Rheumatic Heart disease**
Myocarditis
Emboli
Other conditions **OPC of Liver & Lungs**
(Include pregnancy within 3 months of death)
Major findings: Of operations.....
Of autopsy.....

Duration **Post 3 wks**
Year
3 wks.
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 **Arnold Sklem** (M. D. or other) **MD**
Address **2632 S. Kingshighway** Date signed **2/16/48**

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

MOTHER FATHER

MARR 6 1994

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.....

1994

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.