

No. 300
-10-47
-17-39
P 3908

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

41796

State File No. _____

FILED JAN 11 1949

Registration District No. **318**

Primary Registration District No. **1005**

Registrar's No. **11049**

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:
Enroute City Hospital 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Frank Roth

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widower

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

7. Birth date of deceased July 30 1893
(Month) (Day) (Year)

8. AGE: Years 55 Months 4 Days 19 If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired Baker

11. Industry or business _____

12. Name Unknown Roth

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

14. Maiden name Unknown

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

16. (a) Informant Evelyn Roth

(b) Address 3521 Pestalozzi
Burial (b) Date thereof 12-22-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Peter & Paul

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) DEC 21 1948 (b) J. B. Sasater
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. #5 N. 9th St.
25 (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 19
year 1948 hour 4 minute 25 P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Chronic Myocarditis

Due to Reorganized

Other conditions _____
(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? _____

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

23. Signature Albert H. Hoppe (M. D. or other) _____
Address _____ Date signed 12/21/48

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

MOTHER FATHER

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 Me

....., Registered Apprentice No.

working under my personal supervision.

Signed Elton R. Demelius

Licensed Embalmer No. 4283

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.