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FILED FEB 23 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6614

State File No.

318 1003

1144

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE _____ Mo. _____ b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		17 9	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>3rd. & Walnut Street</u>				d. STREET ADDRESS (If rural, give location) <u>4440 Lindell Blvd.</u>			
3. NAME OF DECEASED a. (First) <u>Julia</u> b. (Middle) <u>Sutherland</u> c. (Last) <u>Roome</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 4, 1949</u>				
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 23-1893</u>		9. AGE (In years last birthday) <u>55</u>	10 UNDER 1 YEAR Months <u>11</u> Days <u>11</u>	11 UNDER 2 HRS. Hours <u>1</u> Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>New Orleans, La.</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <u>William Sutherland</u>		13b. MOTHER'S MAIDEN NAME <u>Katherine Rice</u>		14. NAME OF HUSBAND OR WIFE <u>Charles O. Roome</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Charles O. Roome 4440 Lindell Blvd.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	<p align="center">MEDICAL CERTIFICATION</p> <p>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage (Autentomous)</u></p> <p>ANTECEDENT CAUSES</p> <p>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</p> <p>DUE TO (b) <u>Hypertension (Chronic)</u></p> <p>DUE TO (c) <u>Hypertensive Cardiovascular Disease</u></p> <p>II. OTHER SIGNIFICANT CONDITIONS</p> <p>Conditions contributing to the death but not related to the disease or condition causing death.</p>						INTERVAL BETWEEN ONSET AND DEATH <u>March 5-1949</u> <u>March 5-1949</u>
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>9 444X</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>August G. Dickman - MD</u>				23b. ADDRESS <u>4660 Maryland Ave</u>		23c. DATE SIGNED <u>2/5/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Feb. 5, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) <u>New Orleans, La.</u>		
DATE RECD BY LOCAL REG. <u>FEB 7 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Lasater</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Arthur J. Donnelly 3840 Lindell Blvd</u>			

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

1-3
4660 Maryland Ave
Suite #9

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.....

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed.....

W Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 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.