

FILED MAR 3 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6978

State File No. _____

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>6076</u>		Registrar's No. <u>00269</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)			
a. COUNTY <u>St. Louis</u>				a. STATE <u>Mo.</u>			
b. CITY (If outside corporate limits, write RURAL and give town or township) <u>Maryland Hts.</u>				c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>			
c. LENGTH OF STAY (In this place) _____				d. STREET ADDRESS (If rural, give location) <u>4311 McRee Ave.</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Redwood Ave.</u>							
3. NAME OF DECEASED		a. (First) <u>GERTRUDE</u>		b. (Middle) <u>E.</u>		c. (Last) <u>DeROY</u>	
(Type or Print)		4. DATE OF DEATH		(Month) <u>Feb.</u>		(Day) <u>2</u>	
		(Year) <u>1949</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>Aug. 15, 1871</u>	
9. AGE (In years last birthday) <u>78</u>		IF UNDER 1 YEAR Months <u>5</u>		IF UNDER 24 HRS. Days <u>17</u>		IF UNDER 1 MIN. Hours <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>England</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	
14. NAME OF HUSBAND OR WIFE <u>Late James DeRoy</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT'S SIGNATURE OR NAME <u>Eleanor Kalin</u>				ADDRESS <u>4311 McRee Ave.</u>			
18. CAUSE OF DEATH				MEDICAL CERTIFICATION			
Enter only one cause per line for (a), (b), and (c)				1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cause unknown</u>			
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				ANTECEDENT CAUSES			
				DUE TO (b) _____			
				DUE TO (c) _____			
				11. OTHER SIGNIFICANT CONDITIONS			
				Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		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) _____		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 <u>7:30P m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Thurid Wenger M.D.</u> (Degree or title)				23b. ADDRESS Act. Commr. of Health <u>St. Louis County Health Dept.</u>		23c. DATE SIGNED <u>2-3-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Feb. 5, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		24d. LOCATION (City, town, or county) <u>St. Louis, Mo.</u> (State) _____	
DATE REC'D BY LOCAL REG. <u>2-4-49</u>		REGISTRAR'S SIGNATURE <u>Thurid Wenger</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Kriegshauser</u>		ADDRESS <u>4228 S. Kingshighway Bl.</u>	

Original case (2)

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.

Signed Edwin A. M. Bennett

Signed _____
Student Embalmer

Licensed Embalmer No. 3024

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.

THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF VITAL STATISTICS

6978 47

State of Missouri }
County of St. Louis } ss.

State File No. _____
Local Registrar's No. 269

AFFIDAVIT FOR CORRECTION OF A RECORD

On this tenth day of February, 1949, before me appears _____

_____, who, upon _____ oath, states that the original record of ^{DEATH} death
for Gertrude E. DeRoy ^{died} ~~born~~ February 2, 1949, in the State of
Missouri, and which was filed at St. Louis County Health Department Feb. 4, 1949, should be corrected as follows:

Item No. 8 should read August 15, 1871

Instead of _____ August 15, 1872

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

The above is true to the best of my knowledge, information and belief.

(SEAL)

Affiant Eleanor Katin Daughter
Relationship.

4311 McRee Ave
Present Address.

Subscribed and sworn to before me this 14 day of February, 1949.

My Commission expires Aug. 5-1950 Joseph Katin Notary Public.

