

FILED SEP 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28495

7793

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY <u>Mad.</u>	
b. CITY (If outside corporate limits, write RURAL and give town or township) <u>ST LOUIS</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>ST LOUIS</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST LUKES HOSP.</u>		d. STREET ADDRESS (If rural, give location) <u>17 4431 So BROADWAY</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>THERESA</u>		b. (Middle) <u>ROTHERMEL</u>	
c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>SEP 7 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>Oct 10-1875</u>
9. AGE (In years last birthday) <u>73</u>		10. KIND OF BUSINESS OR INDUSTRY <u>NURSE</u>	
11. BIRTHPLACE (State or foreign country) <u>HIGHLAND ILL</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>FRANK HOFFMAN</u>		13b. MOTHER'S MAIDEN NAME	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT'S SIGNATURE OR NAME <u>HOME OF THE FRIENDLESS</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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of Uterus</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Metastases in chest.</u> 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 <u>none</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <u>Mad.</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <u>172X</u>		22. I hereby certify that I attended the deceased from <u>Nov 1948</u> , to <u>Sept 7, 1949</u> , that I last saw the deceased alive on <u>Sept 3, 1949</u> , and that death occurred at <u>3:45</u> m., from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) <u>Charles E. Hydman M.D.</u>		23b. ADDRESS <u>3-720 Washington</u>	
23c. DATE SIGNED <u>9-8-49</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
24b. DATE <u>SEP 9, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>ST PAULS CHURCHYARD</u>	
24d. LOCATION (City, town, or county) (State) <u>ST LOUIS COUNTY MO</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>C. HOFFMEISTER</u>	
DATE REC'D BY LOCAL REG. <u>SEP 8 1949</u>		ADDRESS <u>COLONIAL MORTUARY</u>	

(Licensed Embalmer's Statement on Reverse Side) 6464 CHIFFE WA

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

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

Harry J. Schumacher

Licensed Embalmer No. *2679*

P. O. Address *7814 So Broadway*

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.