

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 5 1950

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State File No. 31886

Registrar's No. 8164

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony's Hospital		d. STREET ADDRESS (If rural, give location) 3414 Itaska	
3. NAME OF DECEASED a. (First) ALEXANDER b. (Middle) c. (Last) ROMAN			4. DATE OF DEATH (Month) (Day) (Year) Sept. 27, 1950
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Unknown
9. AGE (In years less birthday) Months Days Abt. 82		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Carrie Roman		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Mrs. A. Roman-3414 Itaska	
17. ADDRESS		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial degeneration		DUE TO (b) Prostatic hypertrophy		?
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		Bleeding prostatic hypertrophy		2 wks
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUE TO (c)		

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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 6/10X

22. I hereby certify that I attended the deceased from Sept. 10, 1950, to Sept. 27, 1950, that I last saw the deceased alive on Sept. 27, 1950, and that death occurred at 11:50 A.M., from the causes and on the date stated above.

23a. SIGNATURE A. W. Peters	(Degree or title) M.D.	23b. ADDRESS 4145 a S. Grand Blvd.	23c. DATE SIGNED 9/27/50
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9/29/50	24c. NAME OF CEMETERY OR CREMATORY Mt. Sinai Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri

DATE REC'D BY LOCAL REG. SEP 28 1950	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS 5216 Delmar
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

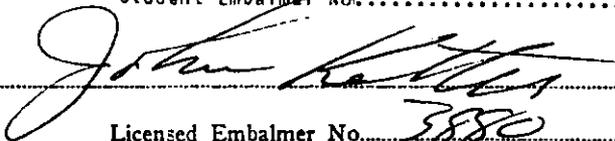
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

working under my personal supervision.

Signed.....
Student Embalmer

Signed

Student Embalmer No.....

Licensed Embalmer No. 3880

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.