

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10500**
2948

FILED APR 12 1952

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

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY JEFFERSON	
b. CITY (If outside corporate limits, write RURAL and give town) ST. LOUIS Mo	c. LENGTH OF STAY (In this place) 3 DAYS	c. CITY (If outside corporate limits, write RURAL and give township) RURAL ROCK TOWNSHIP 0530	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. ANTHONY'S HOSPITAL		d. STREET ADDRESS (If rural, give location) NEAR KIMMSWICK Mo	
3. NAME OF DECEASED a. (First) LOUISE		b. (Middle) ROESCH	c. (Last) _____
4. DATE OF DEATH (Month) (Day) (Year) MAR. 27. 1952.			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH MAY 15, 1864
9. AGE (In years last birthday) 87	10. MONTHS 4	11. BIRTHPLACE (State or foreign country) BELGIUM.	12. CITIZEN OF WHAT COUNTRY? U.S.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK	10b. KIND OF BUSINESS OR INDUSTRY HOME		
13a. FATHER'S NAME UNKNOWN		13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE DECEASED. ROBERT ROESCH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO.	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME PHILIP ROESCH - KIMMSWICK Mo.	
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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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Thrombosis of Right Leg - Primary		INTERVAL BETWEEN ONSET AND DEATH 3 wks
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Type undetermined Chronic Bronchitis		10 yrs.
		DUE TO (c) Arteriosclerotic Heart Disease		15 yrs.
		II. 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 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)	
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 **Feb 2, 1952**, to **Mar 27, 1952**, that I last saw the deceased alive on **Mar 27, 1952**, and that death occurred at **11:45 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE Michael J. Bartmish (Degree or title) M.D.	23b. ADDRESS 7629 So. Broadway	23c. DATE SIGNED 3/27/52
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE MAR 31, 1952	24c. NAME OF CEMETERY OR CREMATORY ST. JOSEPH'S CEMETERY
		24d. LOCATION (City, town, or county) (State) KIMMSWICK Mo.

DATE REC'D BY LOCAL REG. MAR 29 1952	REGISTRAR'S SIGNATURE Charles Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE HEILIGTAG FUNERAL HOME ADDRESS KIMMSWICK Mo.	
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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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed.....

Arthur W. Healey
Embalmer

Licensed Embalmer No.

P. O. Address..... 3872

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.