

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

S. No. 300
EV. 10-48

State File No. **43774**
Registrar's No. **11179**

FILED DEC 24 1952

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
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 2149	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 14 3811 Sulphur	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3811 Sulphur			

3. NAME OF DECEASED (Type or Print) a. (First) Minnie b. (Middle) c. (Last) Roeth		4. DATE OF DEATH (Month) (Day) (Year) Dec. 2 1952	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Sept 20 1870
9. AGE (In years last birthday) 82		10. MONTHS 2	11. DAYS 12
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Christian Reimler		13b. MOTHER'S MAIDEN NAME Anna Peters		14. NAME OF HUSBAND OR WIFE Henry (Deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Robert Foster 3811 Sulphur	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) 10 years		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis		INTERVAL BETWEEN ONSET AND DEATH 10 years	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Acute Bronchial Pneum.		2 weeks	
		DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Advanced age.			
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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 491X	

22. I hereby certify that I attended the deceased from **11-15-1952** to **12-1-1952**, that I last saw the deceased alive on **12-1-1952**, and that death occurred at **8 AM** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Robert B. Foster B.S. M.A.		23b. ADDRESS 3548 Grand Blvd.		23c. DATE SIGNED 12-4-52	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 12/6/52		24c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	
		24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.			

DATE REC'D BY LOCAL REG. DEC 4 1952		REGISTRAR'S SIGNATURE J. Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. Schumacher 3013 Meramec	
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(Licensed Embalmer's Statement on Reverse Side)

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 _____

Jack Haupt

Licensed Embalmer No. *4746*

P. O. Address *St. Francis*

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.