

FILED MAR 15 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6730

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2117**

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 OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony's Hospital		e. STREET ADDRESS (If rural, give location) 15 4235a Dewey Avenue	
c. LENGTH OF STAY (in this place) 74 yrs		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or Print) ADOLPH ROEMHELD			4. DATE OF DEATH (Month) (Day) (Year) Mar. 5, 1954		
a. (First)	b. (Middle)		c. (Last)		
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Mar. 3, 1880		9. AGE (In years last birthday) 74
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired manager		10b. KIND OF BUSINESS OR INDUSTRY Millinery		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME William Roemheld		13b. MOTHER'S MAIDEN NAME Barbara Schachner		14. NAME OF HUSBAND OR WIFE Mathilda (Tillie) Roemheld	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) no		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Tillie Roemheld 4235a Dewey Ave.	

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* Coronary occlusion due to arterio-sclerotic heart disease		ANTECEDENT CAUSES diabetes mellitus, and ischio-rectal abscess			
*This does not mean the mode of dying, such as heart failure, assthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) _____			
		DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS diabetes mellitus, and ischio-rectal abscess		Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION ischio-rectal abscess		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) neither		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? 4200	
22. I hereby certify that I attended the deceased from 3/3, 1954 to 3-5, 1954 that I last saw the deceased alive on 3-5, 1954 , and that death occurred at 10:00 p.m. from the causes and on the date stated above.					

23a. SIGNATURE Joseph E. Don Karel MD (Degree or title)		23b. ADDRESS 634 N Grand Blvd		23c. DATE SIGNED 3/7/54	
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE Mar. 9, 1954		24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park	
		24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri			

DATE REC'D BY LOCAL REG. MAR 8 1954		REGISTRAR'S SIGNATURE J. Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Heiderwieden F. H. Inc., 1936 St. Louis Ave.	
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(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Jos. E. Von Kaenel

Mo. Thirte Bldg.
NE 7618

*Mon. 2-4 PM
no hours Sat*

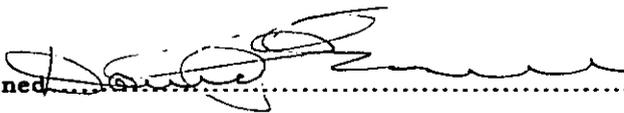
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by _____, Student Embalmer No. _____

working under my personal supervision..

Student _____
Signature of Student Embalmer

Signed  _____

Licensed Embalmer No. 45

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.