

FILED JUL 22 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25681

State File No.

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 547 Registrar's No. 1612

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Richmond Heights</u>		c. CITY OR TOWN <u>St. Louis</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>2wks</u>		e. STREET ADDRESS (If rural, give location) <u>3924 a Wyoming</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Marys Hosp.</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>THOMAS</u> b. (Middle) <u>J</u> c. (Last) <u>ROCHE</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July 5 1954</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov 19 1882</u>
9. AGE (To years last birthday) <u>71</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aggregates Inc</u>	
11. BIRTHPLACE (City and State or Foreign Country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

13a. FATHER'S NAME <u>John Roche</u>		13b. MOTHER'S MAIDEN NAME <u>Ellen Collins</u>		14. NAME OF HUSBAND OR WIFE <u>Margaret Roche</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknowns) <u>No</u>		16. SOCIAL SECURITY NO. <u>489 03 6277A</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Thomas E Roche 3429a Wyoming</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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypostatic Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Fractured left hip</u> DUE TO (c) <u>Cerebral Accident</u>		
	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) <u>Accident</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>St. Louis, Missouri</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>6-23-54</u> a.m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Fell from bed in nursing home.</u>	

22. I hereby certify that I attended the deceased from June 24, 1954 to July 5, 1954 that I last saw the deceased alive on July 5, 1954 and that death occurred at 2:40 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Malcolm B Powell MD</u>		23b. ADDRESS <u>4660 Maryland</u>		23c. DATE SIGNED <u>July 6 1954</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>July 8 54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo</u>		

DATE REC'D BY LOCAL REG. <u>7/7/54</u>	REGISTRAR'S SIGNATURE <u>Walter B. Smith, M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>E. J. Schnur 3125 Lafayette</u>	
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WRITE PLAINLY—USING UNFAADING 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
Signature of Student Embalmer

Signed *Joseph Volkmer*

Licensed Embalmer No. *14010*
P. O. Address *3125 Perry*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.