

FILED SEP 16 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32718

State File No. 2046 Registrar's No. 2046

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500

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 <u>St. Louis</u>	
b. CITY OR TOWN <u>LEMAY, Mo</u>		c. CITY OR TOWN <u>LEMAY 4870</u>	
c. LENGTH OF STAY (in this place) <u>unk</u>		d. Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>505 Tweed DR</u>			
e. STREET ADDRESS (If rural, give location) <u>505 TWEED DR</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>WILLIAM</u>	b. (Middle) <u>F</u>	c. (Last) <u>ROELLE</u>	4. DATE OF DEATH (Month) (Day) (Year)
	<u>WILLIAM F ROELLE 1 SR</u>			<u>AUG. 24 1954</u>

5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>SEPT 7 1879</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR: Months _____ Days _____	IF UNDER 4 HRS: Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED MAINTENANCE MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>INDIANA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>JOSEPH ROELLE</u>	13b. MOTHER'S MAIDEN NAME <u>KATHERINE WAGNER</u>	14. NAME OF HUSBAND OR WIFE <u>MYRTLE ROELLE</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>489-20-9421</u>	17. INFORMANT'S SIGNATURE OR NAME <u>MYRTLE ROELLE</u>	ADDRESS <u>505 Tweed DR.</u>
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Cardiovascular Renal Disease.</u>		<u>5 years</u>
	DUE TO (c) _____		
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 type="checkbox"/>
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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) <u>4201</u>
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 1-21, 1950, to 8-24, 1954, that I last saw the deceased alive on 7-31, 1954, and that death occurred at 8 AM, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Robert A. Brennan M.D.</u>	23b. ADDRESS <u>5417 South Grand</u>	23c. DATE SIGNED <u>8-24-54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	24b. DATE <u>AUG. 27 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>RESURRECTION CEM.</u>	24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Mo</u>
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DATE REC'D BY LOCAL REG. _____	REGISTRAR'S SIGNATURE _____	25. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas Kutis</u>	ADDRESS <u>2906 Gravois</u>
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

*Handwritten mark*

DL 3 - 5511

Death 8<sup>00</sup> a.m.  
until 3 P.M.

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 *Ray Budd*  
Licensed Embalmer No. *398*  
P. O. Address *St. Louis*

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.