

FILED JAN 18 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **43954**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **11657**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (In this place)	
c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>4343 Manchester avenue</b>		• STREET ADDRESS (If rural, give location) <b>18 4343 Manchester avenue</b> <b>21890</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>LORETTA</b> b. (Middle) <b>HELEN</b> c. (Last) <b>ROACH</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>12-21-54</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>2-21-1888</b>
9. AGE (In years last birthday) <b>66</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (City and State or Foreign Country) <b>Rockbridge, Ill.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Edward Smith</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Skean</b>	
14. NAME OF HUSBAND OR WIFE <b>Frank Roach</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>Frank Roach, 4343 Manchester ave.</b>		ADDRESS	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Chronic myocarditis</b> ANTECEDENT CAUSES DUE TO (b) <b>hypertension</b> 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 <b>ND</b>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>ND</b>		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. <b>3</b>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <b>4222</b>			
22. I hereby certify that I attended the deceased from <b>6-5-1932</b> to <b>12-20-1954</b> , that I last saw the deceased alive on <b>12-19-1954</b> , and that death occurred at <b>12 P</b> m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <b>J. P. [Signature]</b>		23b. ADDRESS <b>25700 S. [Address]</b>	
23c. DATE SIGNED <b>12-28-54</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>12-24-54</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>DEC 22 1954 J. Earl Smith, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Rowland-Aker, 4104 Manchester ave.</b>	

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.....  
Signature of Student Embalmer

Signed *J. Allen Davis*  
Licensed Embalmer No. *40*

P. O. Address *How*

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.