Health, Welfare Public Service

300
1-56

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36100
STATE FILE NUMBER

FILED NOV 16 1956

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9555

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis, Mo. Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: BARNES HOSPITAL Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Ill. b. COUNTY: Jefferson
c. CITY OR TOWN: Mt. Vernon Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 209 S. 18 Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First Ben Middle NMN Last Roeder
4. DATE OF DEATH: Month Oct. Day 18 Year 1956
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10-15-1881
9. AGE (In years last birthday): 75 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): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (City and state or country): Jefferson Co.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Louis Roeder
14. MOTHER'S MAIDEN NAME: Mary Fohter
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Lel Ben Garrison Address: Mt Vernon Ill

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypoxia — INTERVAL BETWEEN ONSET AND DEATH: 6 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Respiratory muscle paralysis — 1 week
DUE TO (c) Infectious polyneuroitis — 2 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 364 X
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Oct. 12, 1956, to Oct. 18, 1956 and last saw her/him alive on Oct. 18, 1956
Death occurred at 12:35 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: F. R. Bradley (Degree or title) M. D.
22b. ADDRESS: BARNES HOSPITAL
22c. DATE SIGNED: 10/19/56

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 10-19-56
23c. NAME OF CEMETERY OR CREMATORY:
23d. LOCATION (City, town, or county) (State): Mt. Vernon Ill
24. FUNERAL DIRECTOR: Myers Fun. Service ADDRESS: Mt. Vernon Ill
25. DATE RECD. BY LOCAL REG.: OCT 19 1956
26. REGISTRAR'S SIGNATURE: Earl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

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

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

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Frank Prompf

Licensed Embalmer No. 4

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.