Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-042157

STATE FILE NUMBER

FILED DEC 9 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11266

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis, Missouri — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. Louis Children's Hospital — Length of stay in 1b: 30 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 845 Harlan Ave. — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): John Thomas Roark (Middle, Last)

4. DATE OF DEATH: Month Nov. Day 22 Year 1958

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 7/4/58
9. AGE (In years last birthday): IF UNDER 1 YEAR Months 4 Days 18; IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (City and state or country): St. Louis, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: Matt Frank Roark
13b. MOTHER'S MAIDEN NAME: Josephine Murphy
14. NAME OF HUSBAND OR WIFE: never married

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.: none
17. INFORMANT: Ida Toibb, 500 S. Kingshighway (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Aspiration of gastric contents	1½ hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	General malnutrition & debility	18 days.
DUE TO (c)	Diarrhea, due to Shigella organism	32 days.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 045.7

19. WAS AUTOPSY PERFORMED? YES [X] 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 10/22/58, to 11/22/58 and last saw him alive on 11/22/58
Death occurred at 2:30 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Richard Hardy (Degree or title) M.D.
22b. ADDRESS: 500 S. Kingshighway,
22c. DATE SIGNED: 11/22/58

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 11/23/58
23c. NAME OF CEMETERY OR CREMATORY: Chaple Hill Cemetery
23d. LOCATION (City, town, or county) (State): Waynes County Mo

24. FUNERAL DIRECTOR: JOHN STYGAR & SON — ADDRESS: 5541 RIVERVIEW BLVD.
25. DATE RECD. BY LOCAL REG.: NOV 24 58
26. REGISTRAR'S SIGNATURE: J. Earl Smith M.D. SP.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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. M. Pester

Licensed Embalmer No. 3980

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.