URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS OCT 27 1959

7-59-037142

STATE FILE NUMBER

Registration District No. 976 Primary Registration District No. 4410 Registrar's No. 36

ENDED

1. PLACE OF DEATH
a. COUNTY Phelps
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. James — Length of stay in 1b 4 mo.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION AT home — Inside Limits Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Phelps
c. CITY OR TOWN ST. James — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First William Middle Thos. Last Roske

4. DATE OF DEATH Month Oct. Day 21st Year 1959

5. SEX Male
6. COLOR OR RACE White
7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☐ Child
8. DATE OF BIRTH Feb. 19, 1954
9. AGE (last birthday) 5 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (City and state or country) Chicago, Ill.
12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Alfred Roske
13b. MOTHER'S MAIDEN NAME Billie Mash
14. NAME OF HUSBAND OR WIFE —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT E.T. Mash — Address ST. James, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Familial Muscular dystrophy — INTERVAL BETWEEN ONSET AND DEATH 5 yr.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) — DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

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 10-21-59, to 10-21-59 and last saw her/him alive on 10-21-59
Death occurred at 4:30 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) J. A. Stucker, M.D.
22b. ADDRESS St James Mo
22c. DATE SIGNED 10-22-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE Oct 24 1959
23c. NAME OF CEMETERY OR CREMATORY Masonic Cemetery
23d. LOCATION (City, town, or county) (State) ST. James, Mo.

24. FUNERAL DIRECTOR Oral E. Lickleder — ADDRESS ST. James, Mo
25. DATE RECD. BY LOCAL REG. 10-22-1959
26. REGISTRAR'S SIGNATURE Ruth B. Powell

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

BY AFFIDAVIT OF DOCUMENT

VS OCT 28 1959

STATEMENT BY LICENSED EMBALMER

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

or by Me O, Student Embalmer No.

working under my personal supervision.

Student _____ Signed Orue E Lickli

Signature of Student Embalmer

Licensed Embalmer No. 354

P. O. Address St James

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