

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-042423

FILED VS NOV 16 1959

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 2 9403 Registrar's No. _____

V. S. 300
Rev. 1-57

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1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis,</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Lemay 4860</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Alexion Bros.</u>		Length of stay in 1b <u>5 days</u>	d. STREET ADDRESS (If outside, give location) <u>731 Cumberland Dr.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Herman</u> Middle _____ Last <u>Roesch</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>13,</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 20, 1875</u>	9. AGE (In years last birthday) <u>84</u> 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) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Rosa Roesch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>488-05-0974</u>		17. INFORMANT Address <u>Esther Mason RR 1, Steelville, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL-VASCULAR ACCIDENT</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 WK.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>GENERALIZED ARTERIO-SCLEROSIS,</u>					<u>10 YRS.</u>
DUE TO (c) <u>331X</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>BILATERAL BRONCHOPNEUMONIA</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> 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 <u>1956</u> to <u>10/13/59</u> and last saw her ^{him} alive on <u>10/12/59</u> Death occurred at <u>2:30 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Charles Blad MA.</u>			22b. ADDRESS <u>7430 VIRGINIA AVE</u>		22c. DATE SIGNED <u>10/13/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Oct. 17, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Burial Park</u>	
				23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Hoffmeister Colonial Mortuary 6464 Chippewa St. St. Louis, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>10-14-1959</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u> ms

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

securing the medical certification in the specific manner required by 193.140 MoRS 1949.
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
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 *John S. Demmel*
Licensed Embalmer No. *4194*
P. O. Address

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.