

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-024906

FILED VS JUL 1 1960

318 Primary Registration District No. 1003 Registrar's No. 6257

STATE FILE NUMBER

IDED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony Hospital			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 5302a Murdoch Ave.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First ELLEN Middle A. Last ROACH				4. DATE OF DEATH Month June Day 18 Year 1960					
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 3-25-1897	9. AGE (last birthday) 63	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse (retired)			10b. KIND OF BUSINESS OR INDUSTRY 1 Year		11. BIRTHPLACE (City and state or country) Alexandria, Ontario, Canada		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME James R. Higgins			13b. MOTHER'S MAIDEN NAME Elizabeth Fitzgerald			14. NAME OF HUSBAND OR WIFE Late William P. Roach			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None			16. SOCIAL SECURITY NO. 500-42-0740		17. INFORMANT Address William J. Roach 5302 Murdoch Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage						INTERVAL BETWEEN ONSET AND DEATH 24 hrs.			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertensive Cardiovascular Disease						90 yrs.			
DUE TO (c) 443x									
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. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
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 a.m. p.m. Month, Day, Year									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 8-20-54 to 6-18-60 and last saw her ^{her} alive on 6-17-60 . Death occurred at 7:25 A. m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Do not print) <i>Raymond T. Martin, M.D.</i>				22b. ADDRESS 5203 Chippewa				22c. DATE SIGNED 6-18-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 21, 1960	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) St. Louis, Mo.		(State)		
24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway Blvd.				25. DATE RECD. BY LOCAL REG. JUN 20 1960		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>			

mrc

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed William B. White

Licensed Embalmer No. 429

P. O. Address 428 1/2

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.