

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-019911
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 543 Registrar's No. 1294

AMENDED

FILED MAY 22 1961

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Jennings		c. CITY OR TOWN Jennings	
Length of stay in 1b 41 yrs		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2319 McLaran		d. STREET ADDRESS (If outside, give location) 2319 McLaran	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First MARY Middle A Last ROTH			4. DATE OF DEATH Month May Day 7th , Year 1961		
--	--	--	--	--	--

5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/27/85	9. AGE (last birthday) 76	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) housewife	10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY USA
---	---	---	---

13a. FATHER'S NAME Henry Riemann	13b. MOTHER'S MAIDEN NAME Fredericka Wiebroek	14. NAME OF HUSBAND OR WIFE John H. Roth
--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. FEDERAL SECURITY NO. none	17. INFORMANT John H. Roth, 2319 McLaran
---	---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest		INTERVAL BETWEEN ONSET AND DEATH 12 hrs 5 yrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) atrial fibrillation with mitral stenosis	
	DUE TO (c) Left ventricular hypertrophy	
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 1945 to 5-7-61 and last saw ^{her}him alive on 5-7-61
Death occurred at 11²⁰ P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE L. D. Olson (Degree or title) DD.	22b. ADDRESS 6401 W. Flourissant	22c. DATE SIGNED 5-8-61
---	--	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 5/10/61	23c. NAME OF CEMETERY OR CREMATORY New Bethlehem Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
--	-----------------------------	---	--

24. FUNERAL DIRECTOR DIEDRICH FUNERAL HOME, 8319 Hallsferry	25. DATE RECD. BY LOCAL REG. 5-9-61	26. REGISTRAR'S SIGNATURE John Murphy M.D.
---	---	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

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 J. Haines

Licensed Embalmer No. 4108

P. O. Address Haines Mo

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.