OURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

61-042825
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10510

FILED NOV 28 1961

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis

Length of stay in Ib: 3 days

c. CITY OR TOWN St. Louis, Mo.

Inside Limits: Yes ☐ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis - Little Rock Hospitals, Inc.

Inside Limits: Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location) 4988 Parker Ave.

Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First Barbara Middle Marie Last Roche

4. DATE OF DEATH: Month November Day 10, Year 1961

5. SEX: Female

6. COLOR OR RACE: White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 11-16-1896

9. AGE (last birthday): 64

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): Payroll Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Hospital

11. BIRTHPLACE (City and state or country): St. Louis, Mo.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: John O'Connor

13b. MOTHER'S MAIDEN NAME: Mary Forde

14. NAME OF HUSBAND OR WIFE: James MacRoche

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.

17. INFORMANT: James M. Roche Address: 4988 Parker Ave.

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) HYPERTENSIVE AND ARTERIOSCLEROTIC HEART DISEASE — 10 YRS

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) CHRONIC BRONCHIAL ASTHMA — 20 YRS

DUE TO (c) 241X

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 November 8, 1961 to November 10, 1961 and last saw her alive on Nov. 10, 1961

Death occurred at 10: P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): John Carrier, MD

22b. ADDRESS: 1755 So Grand

22c. DATE SIGNED: 11-13-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: Nov. 14-1961

23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery

23d. LOCATION (City, town, or county) (State): St. Louis, Mo.

24. FUNERAL DIRECTOR: Kriegshauser Mortuary ADDRESS: 4228 So Kingshyway

25. DATE RECD. BY LOCAL REG.: NOV 13 1961

26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D.

DOCUMENT

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 me, or by _____, Student Embalmer No._____ working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed R. W. Stovesand

Licensed Embalmer No. 4007

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.