

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-008649

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District **1003**

Registrar's No. **2260**

**FILED MAR 7 1962**

VS 300  
Rev. 4/59

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1250-0

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**50**

USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY		c. CITY OR TOWN <b>St. Louis.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Alexion Bros.</b>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3110 Providence.</b>				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Dr. Arthur O. Roskopf.</b>						4. DATE OF DEATH Month <b>2</b> Day <b>24</b> Year <b>62</b>							
5. SEX <b>Male.</b>		6. COLOR OR RACE <b>White.</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>7-15-06</b>		9. AGE (last birthday) <b>55</b>		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) <b>Dentist.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Dentist.</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>					
13a. FATHER'S NAME <b>Otto Roskopf.</b>				13b. MOTHER'S MAIDEN NAME <b>Frances McDonald.</b>				14. NAME OF HUSBAND OR WIFE <b>Norma Roskopf.</b>					
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. <b>None.</b>		17. INFORMANT <b>Norma Roskopf, 3110 Providence.</b>							
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) <b>Hypertension with Cerebral Failure 1 yr</b>													
DUE TO (b) <b>Cerebral Arteriosclerosis Cerebral Deceleration 2 yr</b>													
DUE TO (c) <b>Generalized Cerebral Sclerosis 5 yr</b>													
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. <b>446x</b> <input type="checkbox"/> Yes <input 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 checked="" type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>None</b>									
20c. TIME OF INJURY Hour Month, Day, Year		<b>None</b>											
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE					
21. I attended the deceased from <b>Jan 1, 1958</b> to <b>Feb 24 1962</b> and last saw him alive on <b>Feb 23 1962</b> Death occurred at <b>6:45 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <b>Walter Stump MD</b> (Degree or title)						22b. ADDRESS <b>3933 S Grand</b>			22c. DATE SIGNED <b>2-26-62</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2-27-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection.</b>		23d. LOCATION (City, town, or county) <b>St. Louis County.</b>		23e. (SIGNATURE)					
24. FUNERAL DIRECTOR <b>Southern Funeral Home.</b>						ADDRESS		25. DATE RECD. BY LOCAL REG. <b>FEB 26 1962</b>		REGISTRAR'S SIGNATURE <b>Coat Smith. M.D.</b>			

FL 3-4600  
FL 3-8484

**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 James E. Dille

Licensed Embalmer No. 4347  
P. O. Address 6322 Po Grand

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.