

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-024113

STATE FILE NUMBER

Registration District No. 273 Primary Registration District No. 3051 Registrar's No. 95

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>PERRY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>ST. GENEVIEVE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>PERRYVILLE</u>		Length of stay in 1b <u>5 1/2 DAYS</u>	c. CITY OR TOWN <u>ST MARY'S MO</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>PERRY CO MEMORIAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>STAR ROUTE</u>
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>XAVIER</u> Last <u>ROTH</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>24</u> Year <u>1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5/3/93 69</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>OXORA MO</u>
13a. FATHER'S NAME <u>JOSEPH ROTH</u>		13b. MOTHER'S MAIDEN NAME <u>FRANCES ROTH</u>	14. NAME OF HUSBAND OR WIFE <u>THELMA GRITHER</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.	17. INFORMANT <u>Leonard Roth Sr. Moynihan</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>Chronic cardiac decompensation</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 months.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arterio sclerotic heart disease</u>			<u>3 years.</u>
DUE TO (c) <u>Nephros. sclerosis -</u>			<u>u.</u>
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 type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 <u>Dec. 1959</u> to <u>June 24/62</u> and last saw <u>him</u> alive on <u>June 24/62</u> Death occurred at <u>2 40 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Deceased or title) <u>Joseph F. Leavelle MD</u>		22b. ADDRESS <u>St Genevieve, Mo</u>	22c. DATE SIGNED <u>June 25/62</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6/27/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SACKED HEART</u>	23d. LOCATION (City, town, or county) (State) <u>OXORA MO</u>
24. FUNERAL DIRECTOR <u>Lee C. Barker Sr. Genevieve Mo</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>6-26-62</u>	26. REGISTRAR'S SIGNATURE <u>Joe J. Zoellner</u>

JUL 10 1962

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

Adrian J. Ellis

Licensed Embalmer No.

4740

P. O. Address

St. Genevieve, 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.