

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-024294

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 370 Primary Registration District No. 2058 Registrar's No. 177

VS 300
Rev. 4/59

1 0928
2 0920
3
4 0
5 1
6
7 0
8 2
9 420.1
10
11
12 92-0
13 4-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY St. Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Charles	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Charles		Length of stay in 1b D.O.A.	c. CITY OR TOWN St. Charles Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hospital D.O.A.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Route #1 Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JAMES Middle A. Last ROAN			4. DATE OF DEATH Month June Day 29 Year 1962
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-14-1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber (Retired) Self Employed		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) 71 IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME James Patrick Roan		13b. MOTHER'S MAIDEN NAME Elizabeth Amelia Lauman	14. NAME OF HUSBAND OR WIFE Delilah M. Roan
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World War 1		17. INFORMANT Delilah M. Roan Rt. #1 St. Charles, Mo. Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis DUE TO (b) Coronary atherosclerosis DUE TO (c) Atherosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cerebral atherosclerosis			INTERVAL BETWEEN ONSET AND DEATH 1 hour - 4 years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 March 13, 1959 to June 29, 1962 and last saw him alive on June 19, 1962 Death occurred at 3:00 P. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) G. J. Carty M.D.		22b. ADDRESS St. Charles, Mo	
22c. DATE SIGNED June 30, 1962			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE July 3, 1962	
23c. NAME OF CEMETERY OR CREMATORY National Cemetery		23d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo.	
24. FUNERAL DIRECTOR Olivette Kriegshauser 9450 Olive St. Road		25. DATE RECD. BY LOCAL REG. 6/30/62	
26. REGISTRAR'S SIGNATURE Marcella Wilson			

USE BLACK INK
OR
TYPEWRITER RIBBON

JAN 11 1963

JUL 12 1962

AUG 2 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 James R. Dunn

Licensed Embalmer No. 4527

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.