

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-028295

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 306 Primary Registration District No. 6048 Registrar's No. 14

FILED AUG 10 1962

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>O'Fallon</u>		Length of stay in 1b <u>life</u>	c. CITY OR TOWN <u>O'Fallon</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Roeper Nursing Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>423 Woodlawn</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Paul George Roeper</u>			4. DATE OF DEATH Month Day Year <u>Aug. 5, 1962</u>		
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5. SEX <u>male</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-25-1884</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired builder</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Contracting</u>	11. BIRTHPLACE (City and state or country) <u>O'Fallon, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Joseph Roeper</u>	13b. MOTHER'S MAIDEN NAME <u>Therese Merceir</u>	14. NAME OF HUSBAND OR WIFE <u>Pauline Depping</u>
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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. <span style="border: 1px solid black; display: inline-block; width: 100px; height: 15px;"></span>	17. INFORMANT Address <u>Mrs. Pauline Roeper O'Fallon</u>
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18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerosis</u>	
	DUE TO (c) <u>Senility</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	
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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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	
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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
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21. I attended the deceased from 6-17-62 to 8-5-62 and last saw him alive on 8-2-62  
Death occurred at 9:30 p on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Harold G. Maynard D.O.</u>	22b. ADDRESS <u>O'Fallon Mo</u>	22c. DATE SIGNED <u>8-8-62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>8/8/1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Assumption Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>O'Fallon, Mo.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Keithly-Davis Chapel O'Fallon, Mo</u>	25. DATE RECEIVED BY LOCAL REG <u>8/8/62</u>	26. REGISTRAR'S SIGNATURE <u>Ed Keithly</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

VS 300 Rev. 4/59	1 <u>09-21</u>	2 <u>09-21</u>	3 <u>2</u>	4 <u>2</u>	5 <u>1</u>	6	7 <u>0</u>	8 <u>2</u>	9 <u>420.1</u>	10	11	12 <u>86-2</u>	13 <u>2-0</u>
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**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 Jerry A. Davis

Licensed Embalmer No. 5139

P. O. Address O'Fallon, 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.