

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

11307

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **203**

City..... *St. Louis*

(No. *Mo Baptist Sanitarium* St. Ward)

File No.

Registered No. **3145**

2. FULL NAME

John F Roach

(a) Residence. No. *3729 Olive St.* St. *19* Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Male White Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Bert Roach

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Feb 14 1871*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

57 1 5

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Plasterer*

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY) *Wyoming*

10. NAME OF FATHER *John F Roach*

11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY) *Ireland*

12. MAIDEN NAME OF MOTHER *Unknown*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY) *Ireland*

14. INFORMANT *Mr Bert Roach* (Address) *3729 Olive St*

15. FILED *20 1928* *May C Starkey* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2 16. DATE OF DEATH (MONTH, DAY AND YEAR) *Mar-19-1928*

17. I HEREBY CERTIFY, That I attended deceased from *Jan-1-1928*, to *Mar-19-1928* that I last saw him alive on *Mar-19-1928*, and that death occurred, on the date stated above, at *8:30 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

92A 97 74A
arterio-sclerotic cerebral hemorrhage

CONTRIBUTORY (SECONDARY) *arterio-sclerotic* (duration) *1* yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH.....

0 DID AN OPERATION PRECEDE DEATH? *no* DATE OF.....

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *none*

(Signed) *T. H. Hall*, M. D.

3/20, 1928 (Address) *4903 Delaware*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Omaha Neb* DATE OF BURIAL *3-20 1928*

20. UNDERTAKER *Arthur J. Homely* ADDRESS *2039 1/2 Oak St*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

War T Hale

4901 DeGm

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