

DEC 12 1938

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

37876  
Do not use this space.

1. PLACE OF DEATH

(a) County ..... Registration District No. **791**  
 (b) Township ..... Primary Registration District No. **1003** Registered No. **10203**  
 (c) City **St. Louis** (d) Street No. **Josephine Heitkamp Hospital** St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **Catherine M Roche CATHERINE MARGARET M ROCHE**

(a) Residence, No. **5045 A. Chippewa St.** St. **14** (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Thomas J. Roche**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **August 13 1883**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
**55 3 10**

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc. **Housewife**  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Missouri**

13. NAME **William Roche**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ireland**

15. MAIDEN NAME **Catherine McSweeney**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ireland**

17. INFORMANT **Thomas J. Roche**  
 (ADDRESS) **5045 A. Chippewa St**

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE **Calvary Cemetery** DATE **November 26, 1938**

19. FUNERAL DIRECTOR (NAME) **Petz Brothers**  
 (ADDRESS) **3029 Lafayette Ave**

20. FILED **NOV 25 1938** **J. E. Bredeck**  
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **November 24 1938**

22. I HEREBY CERTIFY, That I attended deceased from **11/14/38**, 19, to **11/24/38**, 19.  
 I last saw him alive on **11/23/38**, 19. Death is said to have occurred on the date stated above, at **2:10 A.M.**  
 The principal cause of death and related causes of importance were as follows:

**Intestinal Obstruction** **11/19/38**  
**Caused by an old hernia**  
**operating yrs ago**

Other contributory causes of importance:  
**Cerebral Impairment**, **11/19/38**  
**Post operative**

Name of operation **Intestinal Obstruction** **11/19/38**  
 What test confirmed diagnosis? **X-ray** Was there an autopsy? **No**

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? **No** Date of injury....., 19.....  
 Where did injury occur? (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....  
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? **No**  
 If so, specify **Stephen Dejean**, M. D.  
 (Signed) **Stephen Dejean**  
 (Address) **3202 - 2 Park**

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.

Corrected by affidavit

I 3

see affidavit # 278 in misc file

3202 2nd Back Air  
Box 7395  
9611

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 \_\_\_\_\_

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed Frank J. Burns

Licensed Embalmer No. 2245

P. O. Address St Louis 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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **37876**

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **10203**

**1. PLACE OF DEATH:**  
(a) County.....  
(b) City or town **St. Louis**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Josephine Heitkamp Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
(Specify whether  
In this community.....  
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State..... (b) County.....  
(c) City or town.....  
(If outside city or town limits, write "RURAL")  
(d) Street No.....  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.?..... years.

**3. (a) PRINT FULL NAME** **Margaret M. Roche**

**3. (b) If veteran, name war.**..... **3. (c) Social Security No.**.....

**4. Sex.**..... **5. Color or race**..... **6. (a) Single, widowed, married, divorced**.....

**6. (b) Name of husband or wife**..... **6. (c) Age of husband or wife if alive**..... years

**7. Birth date of deceased**.....  
(Month) (Day) (Year)

**8. AGE:** Years Months Days If less than one day  
..... hr. .... min.

**9. Birthplace**.....  
(City, town, or county) (State or foreign country)

**10. Usual occupation**.....

**11. Industry or business**.....

**MOTHER FATHER** { **12. Name**.....  
**13. Birthplace**.....  
(City, town, or county) (State or foreign country)  
**14. Maiden name**.....  
**15. Birthplace**.....  
(City, town, or county) (State or foreign country)

**16. (a) Informant**.....

**(b) Address**.....

**17. (a)**..... **(b) Date thereof**.....  
(Burial, cremation, or removal) (Month) (Day) (Year)

**(c) Place: burial or cremation**.....

**18. (a) Signature of funeral director**.....

**(b) Address**.....

**19. (a)** **7-6-40** **(b)** **J. F. Beudeck**  
(Data received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month **Nov.** day **24**  
year **1938** hour..... minute..... M.

**21. I hereby certify that I attended the deceased from**.....  
..... 19....., to..... 19.....;  
that I last saw h..... alive on..... 19.....  
and that death occurred on the date and hour stated above.

Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....

Of autopsy.....

**22. If death was due to external causes, fill in the following:**

**(a) Accident, suicide, or homicide (specify)**.....

**(b) Date of occurrence**.....

**(c) Where did injury occur?**.....  
(City or town) (County) (State)

**(d) Did injury occur in or about home, on farm, in industrial place, in public place?**.....

.....  
(Specify type of place)

While at work?..... **(e) Means of injury**.....

**23. Signature**..... **(M. D. or other)**.....

Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

**SUPPLEMENTARY**

5-37876

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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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**