

FILED JUN 14 1943 318

Registration District No. _____

Primary Registration District No. **1003**

Registrar's No. **5117**

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:
3836 A Louisiana Ave.
(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

3. (a) PRINT FULL NAME **Joseph J. Roderique**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **5-4-44**

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

6. (b) Name of husband or wife **Gretchen Roderique** 6. (c) Age of husband or wife if alive **62** years

7. Birth date of deceased **June 17 1867**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	75	11	15	hr. _____ min.

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

10. Usual occupation **Retired**

11. Industry or business _____

12. Name **Joseph Roderique**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Gretchen Roderique**

(b) Address **3836 A Louisiana Ave.**

17. (a) **Burial** (b) Date thereof **6/4/43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Sun S&T Burial Park**

18. (a) Signature of funeral director **Wm. E. Moyall**
1926 Allen Ave.

19. (a) **JUN 3 1943** (b) **J. J. Medek**
(Date of death local register) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
17
 (c) City or town **St. Louis,** **9 16**
(If outside city or town limits, write "RURAL")
 (d) Street No. **3836 A Louisiana Ave.**
(If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **2**
 year **1943** hour **12** minute **45** A. M.

21. I hereby certify that I attended the deceased from **May 21**
1943 to **June 2** 19**43**
 that I last saw him alive on **June 2** 19**43**
 and that death occurred on the date and hour stated above.

Immediate cause of death: **Hypostatic Pneumonia - Lobar** **5 days**

Due to: **Cerebral Hemorrhage - Hypertension** **3 weeks**
Sepsis

Other conditions: **none**
(Include pregnancy within 3 months of death)

Major findings: **108**
 Of operations _____
 Of autopsy **none**

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? _____

While at work? _____
(Specify type of place) (e) Means of Injury.

23. Signature **H. J. Whelan** (M. D. **M.D.**)
 Address **4703 Virginia** Date signed **6-2-43**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FATHER {
MOTHER {

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 ME

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

Signed, W. L. Moyall

Licensed Embalmer No. 1467

P. O. Address 1926 Allen

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, fact should be so stated above.