

S. No. 2  
M-2-43  
5-17-43  
X3358

34210

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED NOV 9 1943

Registration District No. 12

Primary Registration District No. 1000

Registrar's No. 1181

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

1. PLACE OF DEATH

(a) County BUCHANAN

(b) City or town ST-JOSEPH  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1201 - FIFTH - AV.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community LIFE (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County BUCHANAN

(c) City or town ST-JOSEPH  
(If outside city or town limits, write "RURAL")

(d) Street No. 1201 - FIFTH - AVE  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME DARRELL LEROY ROLL

3. (b) If veteran, name war No

3. (c) Social Security No. NONE

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced SO

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased May 30 1943  
(Month) (Day) (Year)

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

0 5 0 hr. min.

9. Birthplace ST-JOSEPH - MO  
(City, town, or county) (State or foreign county)

10. Usual occupation: None

11. Industry or business \_\_\_\_\_

12. Name WILLIE A ROLL

13. Birthplace DONIPHAN CO - MS.  
(City, town, or county) (State or foreign county)

14. Maiden name GRACIE A GRAY

15. Birthplace SPENCER CO - NY  
(City, town, or county) (State or foreign county)

16. (a) Informant W A Roll

(b) Address 818 Parker

17. (a) B (b) Date thereof NOV-1-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ASHLAND-CEM

18. (a) Signature of funeral director Roy Stamey

(b) Address ST-JOSEPH - MO

19. (a) 11-1-43 (b) Rose Herzog  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month OCT day 30  
year 1943 hour 1:55 minute A M.

21. I hereby certify that I attended the deceased from Oct 27 1943 to Oct 30 1943  
that I last saw him live on Oct 29 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death acute dysentery

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration

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 Leroy Backlund (Physician or other)  
Address Boulevard Date signed 11/1/43

10273 (Licensed Embalmer's Statement on Reverse Side)

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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..... *John Roy Stoney*  
Licensed Embalmer No. *2435*  
P. O. Address *St. Joseph 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, fact should be so stated above.**