

S. No. 2
OM-5-43
Rev. 5-17-39
I X36671

FILED MAY 26 1945
Registration District No. **318**

Primary Registration District No. **1003**

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

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:
DePaul Hosp.
(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 Mo (b) County St. Louis

(c) City or town Bel-Nor 1
(If outside city or town limits, write "RURAL" _____)

(d) Street No. 2907 Clearview Dr.
(If rural, give location)

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

3. (a) PRINT FULL NAME Samuel C. DeRoche

3. (b) If veteran, name war _____

3. (c) Social Security No. 488-18-3796

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife Mary DeRoche

6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased Sept 3 1871
(Month) (Day) (Year)

8. AGE: Years 73 Months 8 Days 6
If less than one day _____ hr. _____ min.

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

10. Usual occupation Shoe salesman

11. Industry or business Shoe store

12. Name Clophas DeRoche

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

14. Maiden name Sarah Work

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

16. (a) Informant Mary DeRoche

(b) Address 2907 Clearview

17. (a) burial (b) Date thereof 5-11-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cem

18. (a) Signature of funeral director Drehmann-Harral

(b) MAY 1905 Union Blvd

19. (a) MAY 10 1945 (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 9
year 1945 hour 4:15 minute A. M.

21. I hereby certify that I attended the deceased from 5-5-45
19____, to 5-9- 1945
that I last saw him alive on 5-8- 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis

Due to arteriosclerosis

Due to _____

Other conditions 94
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy no.

Duration

1 day

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? _____

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

23. Signature S. J. [unclear] (M. D. or other) _____
Address 608 Kingsland Date signed 5-10-45

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..... *Albert R. Thompson*

Licensed Embalmer No. *4237*

P. O. Address *St. Louis*

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.