V. S. No. 2
00M—2-43
Rev. 5-17-39
I X35897

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19157
Registrar's No. 5367

FILED JUN 30 1945
Registration District No. 318 Primary Registration District No. 1003

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: De Paul Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Illinois (b) County Fayette
(c) City or town Vandalia
(If outside city or town limits, write "RURAL")
(d) Street No. NR
(If rural, give location)
(e) Citizen of foreign country? 9 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Kelly Roe
3. (b) If veteran, name war World War 1
3. (c) Social Security No. None
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Lottie Roe
6. (c) Age of husband or wife if alive 59 years
7. Birth date of deceased October (Month) 24 (Day) 1890 (Year)
8. AGE: Years 54 Months 7 Days 19 If less than one day hr. min.
9. Birthplace Vandalia (City, town, or county) Illinois (State or foreign country)
10. Usual occupation Retired
11. Industry or business
MOTHER FATHER
12. Name Ezekiel Roe
13. Birthplace Fayette County (City, town, or county) Illinois (State or foreign country)
14. Maiden name Nancy Browning
15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)
16. (a) Informant Lottie Roe
(b) Address Vandalia, Ill.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 6-15-45 (Month) (Day) (Year)
(c) Place: burial or cremation Vandalia, Illinois
18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.
19. (a) JUN 19 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 13 year 1945 hour 3:40 minute P. M.
21. I hereby certify that I attended the deceased from June 7, 1945, to June 13, 1945, that I last saw him alive on June 13, 1945, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Heart failure	
Due to: Hypertensive heart disease	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy: not done	

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 Harold C. Stricker (M. D. or other) MD
Address De Paul Hosp. Date signed 6/15/45

(Licensed Embalmer's Statement on Reverse Side)

5367

5367

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 comply with the above constitutes grounds for revocation of license.)

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