

FILED APR 5 1946
 318

STANDARD CERTIFICATE OF DEATH
 1003

State File No. **11592**
 Registrar's No. **3028**

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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:
Little Sisters Poor) 3225 N. Florissant
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 Year
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County 000
 (c) City or town St. Louis 77
(If outside city or town limits, write "RURAL")
 (d) Street No. 3225 N. Florissant Ave. 920
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Mary Rothgeb
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month March day 30th
 year 1946 hour 6 minute A. M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Widow
 6. (b) Name of husband or wife John Rothgeb 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased: March 20 1864
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 27, 1946, to March 30, 1946
 that I last saw him alive on March 29, 1946
 and that death occurred on the date and hour stated above.
 Immediate cause of death Chronic Myocarditis Duration ???

8. AGE: Years 82 Months 0 Days 10 If less than one day
 hr. _____ min. _____

Due to ✓
 Due to ✓
 Other conditions Acute upper respiratory infection 3 days
(Include pregnancy within 3 months of death)

9. Birthplace St. Louis Mo. 1
(City, town, or county) (State or foreign country)
 10. Usual occupation At Home

Major findings:
 Of operations None
 Of autopsy None
 Underline the cause to which death should be charged statistically.

11. Industry or business _____
 12. Name Peter Brady
 13. Birthplace Ireland
(City, town, or county) (State or foreign country)
 14. Maiden name Elizabeth Cummins
 15. Birthplace Albany New York
(City, town, or county) (State or foreign country)

16. (a) Informant Sister Jeanne
 (b) Address 3225 N. Florissant Ave.
 17. (a) Burial (b) Date thereof 4-1-46
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Calvary Cemetery

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 injury)

18. (a) Signature of funeral director Arthur J. Donnelly
 (b) Address 3840 Lindell Blvd
 19. (a) App 1 1946 J. F. Brock
(Date received local Registrar) (Registrar's signature)

23. Signature James H. Stone (M. D. or other) _____
 Address 2502 Salsbery St Date signed 3-30-46

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

Handwritten signature/initials

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 *Stanley Marshall*

Licensed Embalmer No. *2868*

P. O. Address *3840 Lindell*

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.