

FORM 5-443  
REV. 5-17-39  
I X36571

State File No. \_\_\_\_\_  
Registrar's No. **3458**

**FILED** APR 24 1946  
Registration District No. **318**

Primary Registration District No. **100**

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:  
**Missouri Baptist Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **15 months**  
(Specify whether years, months or days) **38 years**

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County \_\_\_\_\_  
(c) City or town **St. Louis**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **4620 Quincy Street**  
(If rural, give location)  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **MINNIE RODERICK**  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_  
4. Sex **F** / 5. Color or race **W** 6. (a) Single, widowed, married, divorced **M** /  
6. (b) Name of husband or wife **Joseph** 6. (c) Age of husband or wife if alive **70** years  
7. Birth date of deceased **March 27, 1878**  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **April** day **13th**  
year **1946** hour **12:30** minute **a** M.  
21. I hereby certify that I attended the deceased from **June 1**  
19 **45**, to **April 13** 19 **46**;  
that I last saw her alive on **April 12** 19 **46**;  
and that death occurred on the date and hour stated above.  
Immediate cause of death **chronic myocarditis**  
Duration \_\_\_\_\_

8. AGE: Years Months **46**  
**68** **0** **17**  
If less than one day hr. min.

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

9. Birthplace **Springfield, Illinois**  
(City, town, or county) (State or foreign country)  
10. Usual occupation **House-wife**  
11. Industry or business **at home**

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

MOTHER FATHER  
12. Name **John Bentancore**  
13. Birthplace **unknown** **9**  
(City, town, or county) (State or foreign country)  
14. Maiden name **unknown**  
15. Birthplace **unknown** **9**  
(City, town, or county) (State or foreign country)

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 **0**

16. (a) Informant **Joseph Roderick**  
(b) Address **4620 Quincy Street**  
17. (a) **burial** (b) Date thereof **4-15-46**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **St. Matthews Cemetery**  
18. (a) Signature of funeral director **A.W. McLaughlin**  
(b) Address **2301 Lafayette Av. St. Louis, Mo.**  
19. (a) **APR 15 1946** (b) **J. J. Bredick**  
(Date received local registrar) (Registrar's signature)

23. Signature **A. J. Mahler M.D.** (M. D. or other)  
Address **3507 P. Jones** Date signed **4-14-46**

**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..... *E. W. Cooper* .....  
Licensed Embalmer No. *3830* .....  
P. O. Address. *2301 Lafayette A.* .....

**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.**