

1. PLACE OF DEATH:

(a) County Osage
(b) City or town Freedom Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Life /
(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 Osage 76
(c) City or town Freedom E.D. 0
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Fredrick Theo. Roche

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mary Lynch Roche 6. (c) Age of husband or wife if alive 65 years
7. Birth date of deceased November 19-- 1871
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
75 1 2 hr. _____ min.

9. Birthplace Luystown M 0
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name John Roche
13. Birthplace Freedom, Germany 4
(City, town, or county) (State or foreign country)
14. Maiden name Maragret Koch
15. Birthplace Germany U
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Winifred Roche

(b) Address Jefferson City Mo

17. (a) Burial (b) Date thereof 12-24-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Baileys Creek Mo

18. (a) Signature of funeral director Clyde Maston

(b) Address Linn Mo

19. (a) 12-27-46 (b) E. ether Soder
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 21
year 1946 hour 9 minute 30p M.

21. I hereby certify that I attended the deceased from March
1946 to 12-21-46 1946
that I last saw him alive on 12-6-46 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac
Failure

Due to Hypertensive
Cardiovascular disease

Due to _____

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

Major findings: 93D
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? 0

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

23. Signature Brian D Taylor (M. D. or other) M.D.

Address Jefferson City Date signed 12-27-46

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

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed JAN 15 1947

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 *Vernon M. Morton*

Licensed Embalmer No. *4125*

P. O. Address *Levin*

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.