

S. No. 300
OM-10-47
Rev. 5-17-39
I 3906

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. 10606
2927
Registrar's No.

FILED APR 7 1948
Registration District No. 318

Primary Registration District No.

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

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Firmin Desloge Hospital
(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

3. (a) PRINT FULL NAME Roeckle, Marie

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F. / 5. Color or race White

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased JAN. 1 1890
(Month) (Day) (Year)

8. AGE 58 Years Months 2 Days 24
If less than one day hr. _____ min. _____

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

10. Usual occupation SEWER

11. Industry or business NEW ERA SHIRT CO.

12. Name FRANK SCHIEGONICK

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

14. Maiden name THERESA RICHTER

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

16. (a) Informant MRS. JESSE HOLLIDAY

(b) Address GM. R. 105 MIDDLE RD. PEORIA, ILL.

17. (a) BURIAL (b) Date thereof MAR. 27 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation S. S. PETER + PAUL CH.

18. (a) Signature of funeral director Thomas Kuten + Son

(b) Address 2906 GRAYOIS

19. (a) MAR 25 1948 (b) J. F. Breckner
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 000

(c) City or town ST. LOUIS 17
(If outside city or town limits, write "RURAL")

(d) Street No. 1709 S. 12th 9
23 (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No) 0
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3-25-48 day _____
year _____ hour 9:45 A.M. minute _____ M.

21. I hereby certify that I attended the deceased from 12-22-47 19 _____ to 3-25-48 19 _____
that I last saw h. or alive on 3-25-48 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis
inaction Duration 3 months

Due to metastatic carcinoma

Due to Carcinoma of right breast

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

Major findings: 50
Of operations _____

Of autopsy Autopsy performed
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 J. F. Breckner (M. D. or other) _____
Address 1325 South Grand Island Date signed 3-25-48

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.