

FILED JUN 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21595

State File No.

BIRTH NO.

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 5215

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3932 Lexington Ave.		d. STREET ADDRESS (If rural, give location) 3932 Lexington Ave.	
3. NAME OF DECEASED (Type or Print) a. (First) Amanda Roderick b. (Middle) c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) June 15, 1949	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M.	8. DATE OF BIRTH Jan. 11, 1979
9. AGE (In years last birthday) 70		IF UNDER 1 YEAR Months 5 Days 4	IF UNDER 24 HRS. Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME Charles Meisch	
13b. MOTHER'S MAIDEN NAME Charlotte Graffman		14. NAME OF HUSBAND OR WIFE William J. Roderick	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Mr. Wm. J. Roderick, 3932 Lexington		ADDRESS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) Chronic atherosclerosis malignant growth left breast & metastases	
INTERVAL BETWEEN ONSET AND DEATH unknown		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 50		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 17 AX	
22. I hereby certify that I attended the deceased from June 14, 1949 , to June 14, 1949 , that I last saw the deceased alive on June 14, 1949 , and that death occurred at 2:45 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE Herbert Lilsberg MD (Degree or title)		23b. ADDRESS 2739 7/2 Grand Ave	
23c. DATE SIGNED 6/16/49		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE June 18, 1949		24c. NAME OF CEMETERY OR CREMATORY New Bethlehem	
24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.		DATE REC'D BY LOCAL REG. JUN 16 1949	
REGISTRAR'S SIGNATURE J. B. Lasater		25. FUNERAL DIRECTOR'S SIGNATURE Arthur J. Donnelly	
ADDRESS 3840 Lindell Blvd.			

(Licensed Embalmer's Statement (on Reverse Side))

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

W H VanMatre

Signed _____
Student Embalmer

Licensed Embalmer No. _____

2825

P. O. Address _____

4340 Lafayette

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

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