

FILED APR 25 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14945

State File No. _____

318

1003

3543

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 1003		Registrar's No. 3543			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2039			
d. FULL NAME OF HOSPITAL OR INSTITUTION 2043 Knox Ave.				d. STREET ADDRESS (If rural, give location) 2043 Knox Ave.					
3. NAME OF DECEASED (Type or Print) a. (First) JOHN b. (Middle) B. c. (Last) ROTH			4. DATE OF DEATH (Month) (Day) (Year) Apr. 16, 1950						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Mar. 27, 1877			
9. AGE (In years last birthday) 73		IF UNDER 1 YEAR Months 0 Days 19		IF UNDER 24 HRS. Hours _____ Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State of foreign country) Buckingham, Ala.		12. CITIZEN OF WHAT COUNTRY? USA		
13a. FATHER'S NAME VALENTINE ROTH			13b. MOTHER'S MAIDEN NAME CATHERINE UNKNOWN		14. NAME OF HUSBAND OR WIFE ANNA ROTH				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) Unknown			16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Anna Roth, 2043 Knox Ave. St. Louis (10), Mo.				
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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Endo Carditis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Paralysis standing 8 years II. OTHER SIGNIFICANT CONDITIONS* Conditions contributing to the death but not related to the disease or condition causing death. Paralysis Agitans				INTERVAL BETWEEN ONSET AND DEATH 5 days	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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) 4214					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____					
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>42</u> , to <u>April 16th</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>April 15th</u> , 19 <u>50</u> and that death occurred at <u>721p m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <i>Dr. Theodor Schmucker, M.D.</i>				23b. ADDRESS 425 DeBaliviere		23c. DATE SIGNED Apr 17-50			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4-19-1950		24c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Mo. (Co.)			
DATE REC'D BY LOCAL REG. APR 18 1950		REGISTRAR'S SIGNATURE <i>J. B. Lesater</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS JAY B. SMITH, 7150 Manchester Ave. Maplewood 17, Mo.					

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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

H. P. Burgess

Signed
Student Embalmer

Licensed Embalmer No. _____

4029

P. O. Address _____

Maplewood

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.