

No. 300  
10-58

FILED JAN 17 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3412

State File No. \_\_\_\_\_

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>6076</u>		Registrar's No. <u>36</u>							
1. PLACE OF DEATH a. COUNTY <u>St. Louis County</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u>				b. COUNTY <u>St. Louis</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Wellston</u>		c. LENGTH OF STAY (In this place) <u>10 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Webster Groves, Missouri</u>		4587							
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. Vincent's Sanitarium</u>				d. STREET ADDRESS (If rural, give location) <u>219 Hawthorne Avenue</u>				1					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Bertha</u>			b. (Middle) _____			c. (Last) <u>Roesch</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 6 1951</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>		8. DATE OF BIRTH <u>Sept. 14, 1877</u>		9. AGE (In years last birthday) <u>73 1/2</u>		IF UNDER 1 YEAR Months <u>3</u> Day <u>23</u>		IF UNDER 24 HRS. Hours _____ Mins. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Secretary</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Attorney</u>		11. BIRTHPLACE (State or foreign country) <u>Alton, Illinois</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13a. FATHER'S NAME <u>Charles Roesch</u>				13b. MOTHER'S MAIDEN NAME <u>Marie Reichert</u>				14. NAME OF HUSBAND OR WIFE <u>None</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Sister, Mrs. Louise Koenig</u>				ADDRESS <u>219 Hawthorne Webster Groves</u>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)													
MEDICAL CERTIFICATION													
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Uremia</u>										INTERVAL BETWEEN ONSET AND DEATH <u>4 days +</u>			
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.													
ANTECEDENT CAUSES													
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.													
DUE TO (b) <u>Generalized Arteriosclerosis</u>										<u>unknown</u>			
DUE TO (c) <u>Cerebral Arteriosclerosis</u>										<u>unknown</u>			
II. OTHER SIGNIFICANT CONDITIONS													
Conditions contributing to the death but not related to the disease or condition causing death.													
<u>Arteriosclerotic Heart Disease</u>										<u>unknown</u>			
<u>Pott's fracture, left</u>										<u>2 wks.</u>			
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) _____								
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>3:55 p.m.</u>		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>Dec. 27</u> , 19 <u>50</u> , to <u>Jan. 6</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Jan. 6</u> , 19 <u>51</u> , and that death occurred at <u>4:50 p.m.</u> ; from the causes and on the date stated above.													
23a. SIGNATURE (Degree or title) <u>Dr. Bauer M.D.</u>						23b. ADDRESS <u>457 N. Kemphighway</u>			23c. DATE SIGNED <u>1-6-51</u>				
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>1-7-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Upper Alton</u>			24d. LOCATION (City, town, or county) (State) <u>Alton, Ill.</u>						
DATE REC'D BY LOCAL REG. <u>1/7/51</u>		REGISTRAR'S SIGNATURE <u>Robert R. Donke M.D.</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>Albert H. Hoppe</u>			ADDRESS <u>4700 Washington Blvd.</u>				

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.....

*William S. Saffin*

Signed.....

Student Embalmer

Licensed Embalmer No. *4199*

P. O. Address. *St Charles, Mo*

**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.