

FILED MAR 7 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6464**
1534

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital		e. STREET ADDRESS (If rural, give location) 5744 Clemens Ave.	

3. NAME OF DECEASED (Type or Print)	a. (First) Onna	b. (Middle) G.	c. (Last) Roy	4. DATE OF DEATH (Month) (Day) (Year)
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED. NEVER MARRIED. WIDOWED. DIVORCED (Specify) W. 2	8. DATE OF BIRTH Mar. 13, 1871	9. AGE (In years) (Month) (Day) (Min.) 85 11 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife-at home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Bonne Terre, Mo. 0	12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME Lucien Thomure	13b. MOTHER'S MAIDEN NAME Azolea Janis	14. NAME OF HUSBAND OR WIFE Borbeau A. Roy
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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. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr. Edgar L. Roy, 7485 Stratford Ave. U.C.
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cor. of heart DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Poor nutritional state			

19a. DATE OF OPERATION 2-17-55	19b. MAJOR FINDINGS OF OPERATION Cor. of heart - only	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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? 170X
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22. I hereby certify that I attended the deceased from **1-30, 1955** to **2-16, 1955**, that I last saw the deceased alive on **2-15, 1955**, and that death occurred at **12:49 am.**, from the causes and on the date stated above.

23a. SIGNATURE Dr. J. J. [Signature] (Degree or title)	23b. ADDRESS 634 N. [Address]	23c. DATE SIGNED 2-17-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Feb. 18, 1955	24c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery	24d. LOCATION (City, town, or county) (State) Bonne Terre, Mo.
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DATE REC'D BY LOCAL REG. FEB 17 1955	REGISTRAR'S SIGNATURE J. Paul Smith, M.D.	25. GENERAL DIRECTOR'S SIGNATURE ADDRESS Arthur J. Donnelly, 3840 Lindell Blvd.
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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..

Student.....
Signature of Student Embalmer

Signed *Francis William*

Licensed Embalmer No. *356*

P. O. Address *3840 Lund*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.