

FILED APR 26 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

13002

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3058 Registrar's No. 98

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Charles</u>		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN <u>St. Charles</u> d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph's Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>1109 Lindenwood Ave.</u> <span style="float: right;">0923</span>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>TONY</u>	b. (Middle) <u>LOUIS</u>	c. (Last) <u>ROTH</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>April 15, 1955</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 25, 1887</u>	9. AGE (in years last birthday) <u>68</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>St. Charles County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Nicholas Roth</u>	13b. MOTHER'S MAIDEN NAME <u>Susan Schneider</u>	14. NAME OF HUSBAND OR WIFE <u>Anna Keiser Roth</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Anna Roth, St. Charles, Mo.</u>	ADDRESS _____
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>20 hrs.</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>		
	ANTECEDENT CAUSES <u>Due to (b) Arteriosclerotic cardiovascular disease</u>		
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>4221</u>	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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 7-8-, 19 53, to 4-15-, 19 55 that I last saw the deceased alive on 4-15-55, 19, and that death occurred at 12:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Old Towers M.D.</u> (Degree or title)	23b. ADDRESS <u>114 N. Main St., St. Chas. Mo.</u>	23c. DATE SIGNED <u>4-15-55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>April 17, 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Weldon Spring Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Weldon Spring, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>April 16 1955</u>	REGISTRAR'S SIGNATURE <u>Francine Hamilton</u> <u>284.2</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur C. Bane, St. Charles, Mo.</u>	ADDRESS _____
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 *Pharence M. Bills*.....

Licensed Embalmer No. *4375*.....

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

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.