

FILED AUG 17 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25454

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>43</u>		PRIMARY REG. DIST. NO. <u>3007</u>		Registrar's No. <u>449</u>			
1. PLACE OF DEATH a. COUNTY <u>Butler</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Butler</u>					
b. CITY (If outside corporate limits, write RURAL and give township) <u>Poplar Bluff, Mo.</u>		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <u>Poplar Bluff</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>Doctors Hosp.</u>				STREET ADDRESS (If rural, give location) <u>524 N. Sixth St.</u> <u>01240</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mary Lenora Roehm</u>			b. (Middle) _____		c. (Last) _____		4. DATE OF DEATH (Month) (Day) (Year) <u>July 26, 1955</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>July 2, 1891</u>		9. AGE (In years last birthday) <u>64</u> IF UNDER 1 YEAR: Months _____ Days <u>24</u> IF UNDER 11 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>7</u> <u>Hawsville, Kentucky</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>A. J. Summers</u>			13b. MOTHER'S MAIDEN NAME <u>Nancy Collard</u>			14. NAME OF HUSBAND OR WIFE <u>Claude F. Roehm</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. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Claude Roehm Poplar Bluff, Mo.</u>				
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Asphyxiation</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>cardiac failure</u> DUE TO (c) <u>Bilateral pneumonia</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>congestive failure</u>						INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>493X</u>						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) (Min.) _____		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>7-24</u> , 19 <u>55</u> , to <u>7-26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7-26</u> , 19 <u>55</u> , and that death occurred at <u>9:18P</u> m., from the causes and on the date stated above.									
23a. SIGNATURE <u>[Signature]</u> (Degree or title) _____				23b. ADDRESS <u>Poplar Bluff, Mo.</u>			23c. DATE SIGNED <u>8-4-55</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>7-29-55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>City Cem.</u>		24d. LOCATION (city, town, or county) (State) <u>Poplar Bluff, Mo.</u>			
DATE RECD BY LOCAL REG. <u>8/10/55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Frank-Cotrell Poplar Bluff, Mo.</u>				

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

RECEIVED

AUG 15 1955

BUTLER CO. HEALTH CENTER

FILE No. _____

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 *Wallace R. Kriger*

Licensed Embalmer No. *412*

P. O. Address *popo*

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.