

FILED OCT 28 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35160

STATE FILE NUMBER

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 98

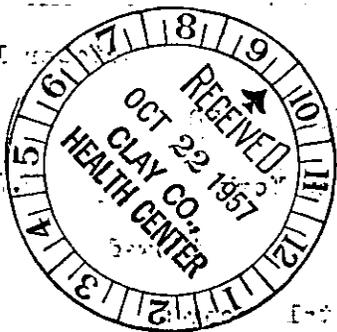
S. 300
1-57

1. PLACE OF DEATH a. COUNTY Clay		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Phelps	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Excelsior Springs, Mo. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. James OR TOWN St. James Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR Veterans Administration INSTITUTION tion Length of stay in 1b 1 yr 5 mo. 17 days		d. STREET ADDRESS Route 1 (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LOUIS Middle NMI Last ROEHM			4. DATE OF DEATH Month October Day 17 Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 20, 1886
9. AGE (In years next birthday) 70		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker	11. BIRTHPLACE (City and state or country) Brooklyn, New York
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10b. KIND OF BUSINESS OR INDUSTRY retired	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME John Roehm		13b. MOTHER'S MAIDEN NAME Mary Heldfrick	14. NAME OF HUSBAND OR WIFE Widowed
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. None	17. INFORMANT Address VA Hospital Records
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Enlargement of heart due to pulmonary disease with decompensation Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Emphysema, pulmonary, extensive DUE TO (c) Tuberculosis, pulmonary, moderately adv. inactive			INTERVAL BETWEEN ONSET AND DEATH 3 yrs 4 yrs 5 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerosis, generalized; Coronary insufficiency			WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) J.B.	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) VA		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. <input checked="" type="checkbox"/> attended the deceased from May 1, 1956 to Oct. 17, 1957 Death occurred at 11:40p m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Clyde V. Kern Chief, Tuberculosis Section		22b. ADDRESS Excelsior Springs, Missouri	
22c. DATE SIGNED 10-18-57			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Oct 18 1957	
23c. NAME OF CEMETERY OR CREMATORY Unknown		23d. LOCATION (City, town, or county) (State) St. James Missouri	
24. FUNERAL DIRECTOR ADDRESS Virgel Hope Ex-Springs Mo.		25. DATE RECD. BY LOCAL REG. 10/18/57	
26. REGISTRAR'S SIGNATURE Caroline Hutchings			

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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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 *James A. Moles* _____

Licensed Embalmer No. *3296*

P. O. Address *Es Springs*

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.