

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38065

STATE FILE NUMBER

FILED OCT 29 1957

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9863**

Health,
Welfare
Public
Service

300
1-56

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. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY <i>St. Louis</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <i>St. Louis</i> Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>St. Louis</i> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) Length of stay in 1b <i>01</i> HOSPITAL OR INSTITUTION <i>3962A PARKER</i>		d. STREET ADDRESS (If outside, give location) Reside on Farm <i>216</i> ADDRESS <i>3962A PARKER</i> Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>MILTON</i> Middle <i>E</i> Last <i>ROEBKE</i>		4. DATE OF DEATH Month <i>Oct</i> Day <i>19</i> Year <i>1957</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MARCH 3, 1903</i>
9. AGE (In years last birthday) <i>54</i>		10. KIND OF BUSINESS OR INDUSTRY <i>ACCOUNTANT</i>	11. BIRTHPLACE (City and state or country) <i>St. Louis, Mo. USA</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>GUS ROEBKE</i>		14. MOTHER'S MAIDEN NAME <i>SALOME GOETZ</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>488-01-6603</i>	
17. INFORMANT <i>MILTON E. ROEBKE</i>		Address <i>3962A PARKER</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Artery Occlusion - Instant.</i> DUE TO (b) <i>Hypertensive Heart Disease</i> DUE TO (c) <i>Auricular Fibrillation</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>4331</i>			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>no injury.</i>	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month _____ Day _____ Year _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office, etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <i>Feb 28 1951</i> to <i>Oct 19 1957</i> and last saw <i>her</i> alive on <i>Sept 28 1957</i> Death occurred at <i>1157A</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>C. Rush McCadam, MD.</i>		22b. ADDRESS <i>906 Olive, St. Louis, Mo.</i>	
22c. DATE SIGNED <i>10-21-57</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>10/22/57</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>FRIEDENS CEMETERY</i>		23d. LOCATION (City, town, or county) (State) <i>ST. LOUIS, Mo.</i>	
24. FUNERAL DIRECTOR <i>J L ZIEGENHEIN & SONS</i>		25. DATE RECD. BY LOCAL REG. <i>OCT 22 '57</i>	
ADDRESS <i>7027 GRAYVOIS</i>		26. REGISTRAR'S SIGNATURE <i>Carl Smith MD</i>	

(Licensed Embalmer's Statement on Reverse Side)

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 *E. P. Kidwell*

Licensed Embalmer No. *387*

P. O. Address *7027 Grace*

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (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.