

Health,  
& Welfare  
Public  
Service

FILED OCT 21 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38703

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2518

1. PLACE OF DEATH a. COUNTY <u>ST. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Normandy</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Rock Hill</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>O'Sullivan Home</u>		Length of stay in 1b <u>10yrs</u>	d. STREET ADDRESS (If outside, give location) <u>315 Euclid</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Vickey Clay Des Roche</u>			4. DATE OF DEATH Month Day Year <u>10 - 10 - 1957</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/12/1874</u>		9. AGE (In years last birthday) <u>83</u>
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 <u>HOME</u>	11. BIRTHPLACE (City and state or country) <u>Glasgow, Ky.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>Wm. Burks</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Joseph Des Roche</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>William Dietz</u> Address <u>3922 N 19th ST</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hypertensive encephalopathy</u>		<u>1 year</u>
	DUE TO (c) <u>Arteriosclerotic cardiovascular disease</u>		<u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic dementia</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	

21. I attended the deceased from July 4, 1957 to Oct 10, 1957 and last saw her alive on Oct 9, 1957.  
Death occurred at 4:15 PM on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Louis Seltman MD</u> (Degree or title)		22b. ADDRESS <u>8231 Clayton Rd</u>		22c. DATE SIGNED <u>10/11/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>10/12/57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem</u>	
<u>BURIAL</u>				23d. LOCATION (City, town, or county) (State) <u>ST. Louis Co MO</u>	

24. FUNERAL DIRECTOR <u>Edw Koch &amp; Son</u> ADDRESS <u>3516 N 14th St</u>		25. DATE RECD. BY LOCAL REG. <u>10-10-57</u>		26. REGISTRAR'S SIGNATURE <u>Herbert R Donahue MD</u>	
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(Licensed Embalmer's Statement on Reverse Side)

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

5-300  
1-57

ase

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 *Walter P. DeLute* .....

Licensed Embalmer No. *4379* .....

P. O. Address *St. Louis, Mo.* .....

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.