

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

46263
STATE FILE NUMBER
Registrar's No. 11947

FILED DEC 19 1957

Registration District No. 318 Primary Registration District No. 1003

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP.		d. STREET ADDRESS (If outside, give location) 3225 Montgomery	
3. NAME OF DECEASED (Type or print) First Middle Last FRED ROEHR		4. DATE OF DEATH Month Day Year DEC, 11, 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 11, 1871
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marble Setter		10b. KIND OF BUSINESS OR INDUSTRY Own business	11. BIRTHPLACE (City and state or country) St. Louis, Missouri
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE -
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Address Mrs. Victor Hugo 6160 Lucille
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LAENNEC'S CIRRHOSIS			INTERVAL BETWEEN ONSET AND DEATH 2 YEARS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			5811
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) MALNUTRITION, BRONCHITIS			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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.)	
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 12/4/57 to 12/11/57 and last saw her alive on 12/11/57 Death occurred at 1:45 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Robert F. Owen, M.D.		22b. ADDRESS 1515 LAFAYETTE AVE.	
		22c. DATE SIGNED 12/11/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 12-12-57	
		23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	
		23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.	
24. FUNERAL DIRECTOR ADDRESS Drehmann-Harral 1905 Union Blvd.		25. DATE RECD. BY LOCAL REG. DEC 12 57	
		26. REGISTRAR'S SIGNATURE J. C. Smith M.D. m & B	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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.

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 *Warren P. Carver*

Licensed Embalmer No. *3534*
P. O. Address

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.