

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003448

STATE FILE NUMBER

2 688

FEB 4 1959

Registration District No.

Primary Registration District No.

Registrar No.

300
57
170
3

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		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis 2239 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 205 N. 9th St.		Length of stay in 1b 9 Yrs.	d. STREET ADDRESS (If outside, give location) 205 N. 9th St. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Walter F. Roth			4. DATE OF DEATH Month Day Year 1 18 1959		
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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	9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Auditor	10b. KIND OF BUSINESS OR INDUSTRY Hotel	11. BIRTHPLACE (City and state or country) Rock Island, Ills.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME William Roth	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Cora L. Roth
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war dates of service) Yes W W I	16. SOCIAL SECURITY NO. 348-18-4082	17. INFORMANT Walter L. Roth, 421 Melrose St. Address Chicago, Ills.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Apical Myocardial Infarction with congestive heart failure; renal failure and hepatic failure leading to uremia		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) renal failure and hepatic failure leading to uremia DUE TO (c) generalized pneumonia	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 420.1		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 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 bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from _____ to _____ and last saw her alive on _____
Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Regina M. Jensen</i>	(Degree of relation) 22b. ADDRESS 1200 Clark	22c. DATE SIGNED 1/20/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 1/23/59	23c. NAME OF CEMETERY OR CREMATORY Chippanock Cemetery	23d. LOCATION (City, town, or county) (State) Rock Island, Ills.
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24. FUNERAL DIRECTOR Drehmann-Harral, 1905 Union Blvd.	25. DATE RECD. BY LOCAL REG. JAN 20 '59	26. REGISTRAR'S SIGNATURE <i>Carl Smith</i>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 *Albert R. Thompson*

Licensed Embalmer No. *4237*
P. O. Address *St. Louis*

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.