

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-018228

STATE FILE NUMBER

Registration District No. 160 Primary Registration District No. 559v Registrar's No. 72

FILED MAY 26 1959

1. PLACE OF DEATH a. COUNTY <u>Jefferson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jefferson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Joachim Twp</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Festus</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Hiway 61</u>		Length of stay in lb <u>Home</u>	d. STREET ADDRESS (If outside, give location) <u>0500 Rte. # 1</u> o

3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Josephine</u> Last <u>Roth</u>			4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>1959</u>			
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 19, 1895</u>	9. AGE (In years last birthday) <u>63</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
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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>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>Walsh, Illinois</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Vincel Baumrucker</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Bietman</u>	14. NAME OF HUSBAND OR WIFE <u>Ben H. Roth</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Ben H. Roth, Rte. # 1, Festus, Mo.</u>	Address
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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) <u>Coronary thrombosis</u>	INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>
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Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertensive heart disease</u>	INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs plus</u>
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DUE TO (c) <u>Myxedema (due to therapeutic use of Radio-active Iodine)</u>	INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs plus</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Myxedema (due to therapeutic use of Radio-active Iodine)</u>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT SUICIDE HOMICIDE <u>No</u> <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.) <u>---</u>
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20c. TIME OF INJURY Hour <u>---</u> Month <u>---</u> Day <u>---</u> Year <u>---</u> a.m. <u>---</u> p.m. <u>---</u>	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.) <u>---</u>	20f. CITY, TOWN, OR LOCATION <u>---</u>	COUNTY <u>---</u>	STATE <u>---</u>
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21. I attended the deceased from <u>January 5, 1937</u> to <u>May 7, 1959</u> and last saw her/him alive on <u>May 7, 1959</u> Death occurred at <u>6:45 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>John F. Rutledge</u> M.D.	22b. ADDRESS <u>Crystal City, Mo.</u>	22c. DATE SIGNED <u>5-8-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>May 9, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Festus Crystal City, Mo.</u>
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24. FUNERAL DIRECTOR <u>Vinyard Fun'l Homes, Inc., Festus, Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>5-11-59</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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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 Heild B. Sigurd

Licensed Embalmer No. 4976

P. O. Address Festus, 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.