

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-023352

STATE FILE NUMBER

2 5707

Filed JUL 1 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

Registrar No. \_\_\_\_\_

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|   |                                  |   |  |  |  |
|---|----------------------------------|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY                                 |  |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>St. Louis</u>   |                                  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  | c. CITY OR TOWN <u>St. Louis</u>   |  |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>4434 Sexauer</u>  |                                  | Length of stay in 1b<br><u>1 year</u>   |  | d. STREET ADDRESS (If outside, give location)<br><u>4434 Sexauer</u>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Fred</u> Middle Last <u>Roth</u>  |                                  |   | 4. DATE OF DEATH<br>Month <u>June</u> Day <u>14</u> Year <u>1959</u> |  |  |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>Nov. 16, 1887</u>   |  |
| 9. AGE (In years last birthday)<br><u>71</u>  |                                  | IF UNDER 1 YEAR<br>Months Days  |  | IF UNDER 24 HRS.<br>Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Milk Driver</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Pevely Dairy</u>  |  | 11. BIRTHPLACE (City and state or country)<br><u>St. Louis, Missouri</u>   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |                                  | 13a. FATHER'S NAME<br><u>Louis Roth</u>   |  | 13b. MOTHER'S MAIDEN NAME<br><u>unknown</u>  |  |
| 14. NAME OF HUSBAND OR WIFE<br><u>Emma Roth</u>   |                                  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>                                      |  | 16. SOCIAL SECURITY NO.<br><u>492-05-9237</u>  |  |
| 17. INFORMANT<br><u>Mrs. Emma Roth</u>  |                                  | Address<br><u>4434 Sexauer</u>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Left Cerebral apoplexy</u><br>DUE TO (b) <u>Chronic Hypertension, Cardio Muscular Disease</u><br>DUE TO (c) <u>443x</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>Diabetes Mellitus</u> |  |
| INTERVAL BETWEEN ONSET AND DEATH<br><u>May 22 - 1959</u>  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" 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.)<br>_____   |                                  | 20c. TIME OF INJURY<br>Hour _____ 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.)<br>_____   |                                  | 20f. CITY, TOWN, OR LOCATION<br>_____   |  | COUNTY _____ STATE _____   |  |
| 21. I attended the deceased from <u>May 22 1959</u> to <u>June 14 1959</u> and last saw <sup>her</sup> <u>him</u> alive on <u>June 11 - 1959</u><br>Death occurred at <u>10:45 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated. |                                  | 22a. SIGNATURE (Degree or title)<br><u>Albert J. Motzel M.D.</u>  |  | 22b. ADDRESS<br><u>2739 NO Grand Bl.</u>   |  |
| 22c. DATE SIGNED<br><u>June 15 - 59</u>   |                                  | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>   |  | 23b. DATE<br><u>June 18, 1959</u>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Oak Grove Mausoleum</u>  |                                  | 23d. LOCATION (City, town, or county)<br><u>St. Louis County, Missouri</u>  |  | (State)  |  |
| 24. FUNERAL DIRECTOR<br><u>Math Hermann &amp; Son, Inc.</u>   |                                  | ADDRESS<br><u>2161 E. Fair</u>  |  | 25. DATE RECD. BY LOCAL REG.<br><u>JUN 16 '59</u>  |  |
| 26. REGISTRAR'S SIGNATURE<br><u>Earl Smith M.D.</u>   |                                  | _____   |  | _____  |  |

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 *Alan W. Hart* ....., Student Embalmer No. ....

Licensed Embalmer No. *3737*  
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.