

JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 22 1959

59-034699

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 2488 STATE FILE NUMBER

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| 1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ILL.</u> b. COUNTY <u>ST. CLAIR</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>RICHTMOND HEIGHTS ST. LOUIS CO. MO.</u> | | Length of stay in 1b <u>3 weeks</u> | c. CITY OR TOWN <u>Belleville</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>ST. MARYS Hosp.</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>Bellevue Apts, Belleville, Ill</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Wendell</u> Last <u>ROETTER</u> | | | 4. DATE OF DEATH Month <u>Sept</u> Day <u>16</u> Year <u>1959</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</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>2-8-1896</u> | 9. AGE (last birthday) <u>64</u> | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HR Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES MAN</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u> | | 11. BIRTHPLACE (City and state or country) <u>Jefferson City, Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |

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| 13a. FATHER'S NAME <u>William Henry Roetter</u> | 13b. MOTHER'S MAIDEN NAME <u>LEONA STRAUB</u> | 14. NAME OF HUSBAND OR WIFE <u>Elizabeth Major Roetter</u> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes World War I</u> | 16. SOCIAL SECURITY NO. <u>492-03-3349</u> | 17. INFORMANT <u>Mrs. Elizabeth Roetter, Bellevue Apts, Belleville, Ill.</u> |
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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>Cardiovascular Renal Disease</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u> <u>6 mo</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | ___ DUE TO (b) <u>Diverterculitis of Sigmoid colon</u> | |
| | ___ DUE TO (c) <u>Cancer of Colon</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>Diverterculitis of Sigmoid colon</u> | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
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| 19. WAS AUTOPSY PERFORMED? 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.) |
| 20c. TIME OF INJURY Hour <u> </u> Month, Day, Year <u> </u> a.m. <u> </u> p.m. <u> </u> | | |

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| 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 <u>Aug 18 1959</u> to <u>Sept 16 1959</u> and last saw her alive on <u>Sept 16 1959</u> Death occurred at <u>12:30 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | |

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| 22a. SIGNATURE <u>John W. Stewart MD</u> (Degree or title) | 22b. ADDRESS <u>4660 Maryland Ave</u> | 22c. DATE SIGNED <u>9-17-59</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>Sept 18, 1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Bowling Green Cem. Bowling Green, Mo.</u> | 23d. LOCATION (City, town, or county) (State) |

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| 24. FUNERAL DIRECTOR <u>Bankhead Funeral Chapel</u> | ADDRESS | 25. DATE RECD. BY LOCAL REG. <u>9-17-59</u> | 26. REGISTRAR'S SIGNATURE <u>John B. Mumfry M.D.</u> |
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 29 1958

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Harold C. Kirk

Licensed Embalmer No. 4597

P. O. Address Bowling Green

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.