

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

318

1003

-61-023100

STATE FILE NUMBER

AMENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **6325**

FILED JUL 13 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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		Length of stay in 1b 68 yrs.	c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 7802 Wanda		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 7802 Wanda		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WALTER Middle C. Last ROELLIG			4. DATE OF DEATH Month July Day 6 Year 1961		
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/14/192	9. AGE (last birthday) 68 yrs.	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY Beverage Mfg.	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME William R. Roellig		13b. MOTHER'S MAIDEN NAME Lena Huning		14. NAME OF HUSBAND OR WIFE Helen Moseley Roellig	
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.		17. INFORMANT Address Mrs. Helen Roellig, 7802 Wanda, St. Louis	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION					INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) ARTERIOSCLEROTIC HEART DIS					10 YRS
DUE TO (c) DIABETES MELLITUS					15 YRS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) THYROID GLAND CYST 260x					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
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 _____ a.m. _____ p.m. Month, Day, Year					
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 SEPT. 1960 to JULY 6, 1961 and last saw her/him alive on JULY 1, 1961 Death occurred at 9:30 A. m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (In free or title) Joseph R. Macko, MD			22b. ADDRESS 634 N. GRAND		22c. DATE SIGNED 7/7/61
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE July 10, 1961	23c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park		23d. LOCATION (City, town, or county) St. Louis County, Missouri.
24. FUNERAL DIRECTOR ADDRESS Beiderwieden F.H.Inc., 1936 St. Louis			25. DATE RECD. BY LOCAL REG. JUL 7 1961		26. REGISTRAR'S SIGNATURE Roan Smith, M.D.

OK 2-0655
10:1 P.M.

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 _____

Licensed Embalmer No. _____

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.