

318 1003 9731-61-039149
 STATE FILE NUMBER

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

1. PLACE OF DEATH
 a. COUNTY _____
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS Length of stay in 1b _____
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. ANTHONY HOSP. Inside Limits No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE MO. b. COUNTY _____
 c. CITY OR TOWN ST. LOUIS Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) 4371 THOLOZAN Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last FRANK ROSKOWSKE 4. DATE OF DEATH Month Day Year OCT. 20 1961

5. SEX MALE 6. COLOR OR RACE WHITE 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH FEB 11 1900 9. AGE (last birthday) 61

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Employee 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (City and state or country) ST. LOUIS MO. 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Herman Roskowske 13b. MOTHER'S MAIDEN NAME Christine Hosfeld 14. NAME OF HUSBAND OR WIFE ELSIE ROSKOWSKE

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. NONE 17. INFORMANT Address ELSIE ROSKOWSKE 4371 THOLOZAN

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION INTERVAL BETWEEN ONSET AND DEATH 4 HRS.
 DUE TO (b) ARTERIOSCLEROTIC CORONARY HEART DISEASE UNK
 DUE TO (c) 4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) ACUTE ANTERIOR MYOCARDIAL INFARCTION 1 1/2 HRS AGO

PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 MAR -7-60 to OCT 20 61 and last saw him alive on OCT 18-1961
 Death occurred at 2:02 p. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Henry Cooper M.D. 22b. ADDRESS 115 Olive St. 22c. DATE SIGNED 10/21/61

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL 23b. DATE OCT 23, 1961 23c. NAME OF CEMETERY OR CREMATORY LAKE CHARLES 23d. LOCATION (City, town, or county) (State) ST. LOUIS CO. MO.

24. FUNERAL DIRECTOR ADDRESS THOMAS KUTIS 2906 GRAVOIS 25. DATE RECD. BY LOCAL REG. OCT 23 1961 26. REGISTRAR'S SIGNATURE Loard Smith, M.D.

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

12-3 Sat.
RM 1115

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 *Looby Thompson*

Licensed Embalmer No. 4861
P. O. Address Blayton 5, 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.