

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

6775-62-029096
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. _____

FILED JUL 31 1962

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN	a. STATE	b. COUNTY
	<u>St. Louis, Mo.</u>	<u>Missouri</u>	<u>Carter</u>
Length of stay in 1b		c. CITY OR TOWN	Inside Limits
<u>5 Days</u>		<u>Geandin</u>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location)	Reside on Farm
<u>Barnes Hospital</u>			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH	
First	Middle	Last	Month	Day
<u>Sherman Roam</u>			<u>July</u>	<u>5, 1962</u>
5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)
<u>Male</u>	<u>White</u>		<u>5/21/1941</u>	<u>21</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY
<u>Farme, Work</u>		<u>Farming</u>	<u>Grandin, Mo.</u>	<u>U.S.A.</u>
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE	
<u>Reagan Roam</u>		<u>Genevieve Thompson</u>	<u>Nil.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address	
<u>No.</u>		<u>Nil.</u>	<u>Reagon Roam, Grandin, Mo.</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Subdural hemorrhage; resulting from fracture of the skull; suffered when car in which deceased was a passenger went out of control, in the vicinity of Hunter, Mo., Carter County, about 2:00AM.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) July 1st, 1962 ACCIDENT

DUE TO (c) _____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.)	
		<u>(See above)</u>	
20c. TIME OF INJURY	Hour	Month, Day, Year	
<u>2:00A.M.</u>	<u>a.m.</u>	<u>7/1/62</u>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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
	<u>street</u>	<u>Hunter, Carter County,</u>	<u>Missouri</u>

21. I attended the deceased from _____ to _____ and last saw her alive on _____		22a. SIGNATURE (Degree or title)		22b. ADDRESS	22c. DATE SIGNED
Death occurred at <u>7:10 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.		<u>Paul J. Simon Deputy Coroner</u>		<u>1300 Clark</u>	<u>7/9/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)		
<u>Removal</u>	<u>7-9-62</u>	<u>Grandin Cemetery</u>	<u>Grandin, Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE			
<u>Albert H. Hoppe Inc., 4700 Washington, Blvd</u>	<u>JUL 9 1962</u>	<u>Karl Smith, M.D.</u>			

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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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 John J. Haines
Licensed Embalmer No. 4108

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.