

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-013752

STATE FILE NUMBER

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 3384

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED MAR 28 1963	
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>ST. LOUIS, MISSOURI</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u> Length of stay in 1b</p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Mo.</u> b. COUNTY <u>Mississippi</u></p> <p>c. CITY OR TOWN <u>East Prairie</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>513 Tylor</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>
<p>3. NAME OF DECEASED (Type or print)</p> <p style="text-align: center;">First Middle Last <u>JOHN H. ROACH</u></p>	<p>4. DATE OF DEATH</p> <p style="text-align: center;">Month Day Year <u>MARCH 20 1963</u></p>
<p>5. SEX <u>Male</u></p> <p>6. COLOR OR RACE <u>White</u></p>	<p>7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/></p> <p>8. DATE OF BIRTH <u>8-8-1889</u></p> <p>9. AGE (last birthday) <u>73</u></p>
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u></p> <p>10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u></p>	<p>11. BIRTHPLACE (City and state or country) <u>Mississippi Co., Mo.</u></p> <p>12. CITIZEN OF WHAT COUNTRY <u>USA</u></p>
<p>13a. FATHER'S NAME <u>Oliver Roach</u></p>	<p>13b. MOTHER'S MAIDEN NAME <u>Mary Yates</u></p> <p>14. NAME OF HUSBAND OR WIFE</p>
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u></p>	<p>16. SOCIAL SECURITY NO. <u>none</u></p> <p>17. INFORMANT <u>J. D. Roach - Peoria, Illinois - Son</u> Address</p>
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <u>DIABETES MELLITUS</u></p> <p>Conditions, if any, which gave rise to above cause - (a), stating the underlying cause last. DUE TO (b) <u>2604</u></p> <p style="text-align: center;">DUE TO (c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pyelonephritis</u></p> <p>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</p>	
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p> <p>20c. TIME OF INJURY Hour s.m. p.m. Month, Day, Year</p>	<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p> <p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> <p>20f. CITY, TOWN, OR LOCATION COUNTY STATE</p>
<p>21. I attended the deceased from <u>11/12/62</u> to <u>3/20/63</u> and last saw her alive on <u>3/20/63</u></p> <p>Death occurred at <u>10:20 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.</p>	
<p>22a. SIGNATURE (Degree or title) <u>[Signature] M.D.</u></p>	<p>22b. ADDRESS <u>BARNES HOSPITAL</u></p> <p>22c. DATE SIGNED <u>3/21/63</u></p>
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p> <p>23b. DATE <u>3-23-63</u></p> <p>23c. NAME OF CEMETERY OR CREMATORY <u>Dogwood</u></p>	<p>23d. LOCATION (City, town, or county) (State) <u>R. R. #1, East Prairie, Mo.</u></p>
<p>24. FUNERAL DIRECTOR <u>McMikle Funeral Home</u> ADDRESS <u>East Prairie, Mo.</u></p>	<p>25. DATE RECD. BY LOCAL REG. <u>MAR 23 1963</u></p> <p>26. REGISTRAR'S SIGNATURE <u>[Signature] M.D.</u></p>

USE BLACK INK OR TYPEWRITER RIBBON

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

James L. Lawson

Licensed Embalmer No. 5168

P. O. Address Millstadt, Illinois

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.