

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

32944

Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No. **791**
 (b) Township Primary Registration District No. **1008** Registered No. **8998**
 (c) City **St. Louis** (d) Street No. **Barnes Hospital** St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Joseph C Trower

(a) Residence, No. St. **KR Bellflower Mo.**
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX <i>male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Bessie Trower</i>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>Apr. 6, 1901</i>		
7. AGE YEARS <i>36</i>	MONTHS <i>5</i>	DAYS <i>24</i>
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <i>Farmer</i>		11. Total time (years) spent in this occupation <i>life</i>
9. Industry or business in which work was done, as saw mill, bank, etc. <i>General farming</i>		
10. Date deceased last worked at this occupation (month and year) <i>9-10-37</i>		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Clinton Missouri</i>		
13. NAME <i>Joseph C Trower</i>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Lincoln Co. Missouri</i>		
15. MAIDEN NAME <i>Dora E. Parsons</i>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Lincoln Co. Missouri</i>		
17. INFORMANT (ADDRESS) <i>Bessie Trower Bellflower Mo.</i>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Massadoma</i> DATE <i>9-27</i> 19 <i>37</i>		
19. FUNERAL DIRECTOR (ADDRESS) <i>Wland A Jones Bellflower Mo.</i>		
SEP 27 1937 <i>St Bredeck</i> Local Registrar.		

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *9-25* 19*37*

22. I HEREBY CERTIFY, That I attended deceased from *9-17* 19*37*, to *9-25* 19*37*

I last saw him alive on *9-25* 19*37*. Death is said to have occurred on the date stated above, at *12:40 pm*.

The principal cause of death and related causes of importance were as follows:
Acute appendicitis
Peritonitis, generalized

Other contributory causes of importance:
Incision & drainage of abscess Date of *9-25-37*

What test confirmed diagnosis? *Operation* Was there an autopsy? *no*

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury 19.....
 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify *Eugene M. Bricker* M. D.
 (Signed) *Eugene M. Bricker* (Address) *Barnes Hosp.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.....
hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....
..... L. E.
No.....or by....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.)