

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH43881
State File No. _____
Registrar's No. 11238

DEC 24 1952

BIRTH NO. 88761 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 4 days	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2069
d. FULL NAME OF HOSPITAL OR INSTITUTION Christian Hospital			d. STREET ADDRESS (If rural, give location) 6 5745 Theodosia Avenue.		
3. NAME OF DECEASED (Type or Print) a. (First) LETA b. (Middle) KAY c. (Last) TROTTER		4. DATE OF DEATH Dec 5, 1952			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Dec 1, 1952	9. AGE (In years last birthday) 4	IF UNDER 1 YEAR Months 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Herman Trotter		13b. MOTHER'S MAIDEN NAME Mattie Duncan	14. NAME OF HUSBAND OR WIFE None		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no none		16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Herman Trotter, 5745 Theodosia Ave		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital Heart Disease ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH Birth
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		7544
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR		
22. I hereby certify that I attended the deceased from 1 Dec 1952, to 5 Dec 1952, that I last saw the deceased alive on 4 Dec 1952, and that death occurred at 4:35 P. M., from the causes and on the date stated above.					
23a. SIGNATURE Luke A. Kneese MD (Degree or title)			23b. ADDRESS 1506 Hadamont Ave		23c. DATE SIGNED 6 Dec 1952
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 4		24b. DATE Dec 6, 1952	24c. NAME OF CEMETERY OR CREMATORY Lake Charles Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Co, Missouri.	
DATE REC'D BY LOCAL REG. DEC 6 1952		REGISTRAR'S SIGNATURE J. Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Shepard Funeral Home, 1167 Hamilton Ave	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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
Student Embalmer

Signed Maile Shepard

Licensed Embalmer No. 3555

P. O. Address _____

Not Embalmed

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 this body is not embalmed, fact should be so stated above.