

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34559

State File No. \_\_\_\_\_

FILED OCT 9 - 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 548 Registrar's No. 2550

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>TEXAS</u>	
b. CITY OR TOWN <u>WEBSTER GROVES</u>	c. LENGTH OF STAY (in this place) <u>7 mo</u>	c. CITY OR TOWN <u>LICKING</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1101 S. ELM AVE</u>		e. STREET ADDRESS (If rural, give location) <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>BERTHA</u>	b. (Middle) <u>ELIZABETH</u>	c. (Last) <u>TROUT</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>SEPT. 29, 1953</u>
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED 2</u>	8. DATE OF BIRTH <u>3-3-1884</u>	9. AGE (In years last birthday) <u>69</u>	10. UNDER 1 YEAR Months _____ Days _____	11. UNDER 1 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>CAPE GIRARDEAU, MO</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>JAMES A ANGEL</u>	13b. MOTHER'S MAIDEN NAME <u>ELIZABETH HILDER</u>	14. NAME OF HUSBAND OR WIFE <u>JOHN TROUT</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>ROSCOE BUCKNER</u>	ADDRESS <u>1101 S. ELM AVE</u>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>18 Hrs.</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of the Colon</u>		
	ANTECEDENT CAUSES 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. <u>153X</u>		

19a. DATE OF OPERATION <u>4/18/53</u>	19b. MAJOR FINDINGS OF OPERATION <u>Advanced Obstructing Carcinoma of Colon</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) _____
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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? _____
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22. I hereby certify that I attended the deceased from 4/11, 1953, to 9/29, 1953, that I last saw the deceased alive on 9/29, 1953 and that death occurred at 12:40 a.m., from the causes and on the date stated above.

22a. SIGNATURE <u>Emmett T Houston, M.D.</u>	(Degree or title)	22b. ADDRESS <u>106 So Central</u>	22c. DATE SIGNED <u>9/29/53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL VIA MOTOR</u>	24b. DATE <u>9-29-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>BOONE CREEK CEM.</u>	24d. LOCATION (City, town, or county) (State) <u>LICKING MO.</u>
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DATE REC'D BY LOCAL REG. <u>9/29/53</u>	REGISTRAR'S SIGNATURE <u>Walter R. ...</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>MITTELBERG FUNERAL HOME</u>	ADDRESS <u>73 W. LOCKWOOD AVE WEB. G. R.</u>
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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.....  
Signature of Student Embalmer

Signed *John S. Denne*  
Licensed Embalmer No. *419*  
P. O. Address *St. Louis*

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.