

FILED OCT 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36061

BIRTH MO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8615

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. CITY OR TOWN ST. LOUIS	
c. LENGTH OF STAY (in this place) 2 WKS.		d. In 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. ST. LOUIS CITY HOSPITAL		e. STREET ADDRESS (If rural, give location) 24 2904 Cherokee ST.	

3. NAME OF DECEASED (Type or Print) SUSAN	a. (First)	b. (Middle)	c. (Last) TROKEY	4. DATE OF DEATH (Month) (Day) (Year) SEPTEMBER 21, 1954
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5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Widowed	8. DATE OF BIRTH Sept. 20-1879	9. AGE (In years last birthday) 75	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (City and State or Foreign Country) Bliss, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME David Sampson	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE Eli Trokey
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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) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Marie Trokey - 2986 Cherokee St. Louis, Mo.	ADDRESS
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized abdominal metastatic mucous carcinoma		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Muscular atrophy		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 153X

22. I hereby certify that I attended the deceased from 9-6-54, 19__, to 9-21-54, 19__, that I last saw the deceased alive on 9-21-54, 19__, and that death occurred at 5:45A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) J. M. Schuster Jr.	23b. ADDRESS 1515 Lafayette Avenue	23c. DATE SIGNED 9-21-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 9-23-54	24c. NAME OF CEMETERY OR CREMATORY ST. STEPHENS RICHWOODS, MO.	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL SEP 21 1954	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE Lee Mathershad - We Sato, Mo	ADDRESS
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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.. *Andrew H. England*

Licensed Embalmer No..... *474*

P. O. Address... *De Soto,*

**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.**