

FILED NOV 26 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40241**
Registrar's No. **2402**

BIRTH NO. _____ REG. DIST. NO. **312** PRIMARY REG. DIST. NO. **500**

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| 1. PLACE OF DEATH a. COUNTY St. Louis Co. | | 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) Manchester | | c. CITY OR TOWN St. Louis | |
| c. LENGTH OF STAY (In this place) 3 wks. | | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Pine Crest Home | | STREET ADDRESS (If rural, give location) 5451 Genevieve | |

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|--|------------|-------------|--------------------------|----------------------------------|---------|-------|--------|
| 3. NAME OF DECEASED (Type or Print) John | a. (First) | b. (Middle) | c. (Last) Trowell | 4. DATE OF DEATH 10/11/56 | (Month) | (Day) | (Year) |
|--|------------|-------------|--------------------------|----------------------------------|---------|-------|--------|

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|--------------------|-------------------------------|---|-------------------------------------|---|---------------------------|--------------------------|---------------------------|--------------------------|
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married | 8. DATE OF BIRTH July 4 1880 | 9. AGE (In years last birthday) 76 | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | IF UNDER 24 HRS. Hours | IF UNDER 24 HRS. Min. |
|--------------------|-------------------------------|---|-------------------------------------|---|---------------------------|--------------------------|---------------------------|--------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Pipefitter | 10b. KIND OF BUSINESS OR INDUSTRY Automatic Sprinkler | 11. BIRTHPLACE (City and State or Foreign Country) Paducah, Kentucky | 12. CITIZEN OF WHAT COUNTRY? USA |
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| 13a. FATHER'S NAME Hiram Trowell | 13b. MOTHER'S MAIDEN NAME Emma Arnot | 14. NAME OF HUSBAND OR WIFE Josie Trowell nee Meyer |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Y, N, or unknown) No | (If yes, give war or dates of service) None | 16. SOCIAL SECURITY NO. Unknown | 17. INFORMANT'S SIGNATURE OR NAME Mrs. Josie Trowell | ADDRESS 5451 Genevieve Avenue, 20 |
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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, asphyxia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Myocarditis DUE TO (c) Arteriosclerosis | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 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) (Min.) | 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 **Sept 22, 1956**, to **Oct 11, 1956**, that I last saw the deceased alive on **Oct 8, 1956**, and that death occurred at **5:55 p.m.**, from the causes and on the date stated above.

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| 23a. SIGNATURE R. N. Jensen | (Degree or title) M.D. | 23b. ADDRESS 1726 Del Norte Maplewood Mo | 23c. DATE SIGNED 10/12/56 |
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|---|---------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE 10/15/56 | 24c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery | 24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri |
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| DATE REC'D BY LOCAL REG. 10-13-56 | REGISTRAR'S SIGNATURE Herbert B. Donahue | FUNERAL DIRECTOR'S SIGNATURE CALVIN F. FEUNTUN | ADDRESS 4828 Natural Bridge Blvd., FUNERAL HOME, INC., St. Louis, 15, Mo. |
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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..... *Ralph T. Lunderal*

Licensed Embalmer No. *4278*

P. O. Address *St. Louis, Mo.*

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.