Health, Welfare Public Service

300
1-56

Doctor, Coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED SEP 17 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34241
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8195

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, give TOWNSHIP only) OR TOWN St Louis — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) City Hospital — Length of stay in 1b 25	d. STREET ADDRESS (If outside, give location) 509 S Bdway — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print)	First Fred	Middle Troxtell	Last	4. DATE OF DEATH Month 8/12/57 Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH Mar 25 1893	9. AGE (In years last birthday) 64 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk.	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Unk 9	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Unk.			14. MOTHER'S MAIDEN NAME Unk	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW 1		16. SOCIAL SECURITY NO. Unk.	17. INFORMANT Address St Louis Police Dept	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Subdural hematoma when found
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) in rear of 9215 Riverview Blvd. on
DUE TO (c) August 10, 1957 Time Place and manner

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 9369 of same could not be determined 48

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) open Verdict

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
Death occurred at 7:37 P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Patrick E. Taylor 3	22b. ADDRESS 1300 Clark	22c. DATE SIGNED 9/3/57

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9/3/57	23c. NAME OF CEMETERY OR CREMATORY National Cem.	23d. LOCATION (City, town, or county) (State) Jeff Bks. Mo
24. FUNERAL DIRECTOR ADDRESS Edward Fendler 5611 South Grand Blvd		25. DATE RECD. BY LOCAL REG. SEP 3 57	26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. M.J.B

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

Not Embalmed

working under my personal supervision..

Ear. Tender

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
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.