

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-008437
State File No.

FILED MAR 5 - 1958

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 381

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give town) KOCH Mo		c. CITY OR TOWN ST. LOUIS	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) 31 days		e. STREET ADDRESS (If rural, give location) 2710 2645- BERNARD	
d. FULL NAME OF HOSPITAL OR INSTITUTION ROBERT KOCH HOSPITAL			
3. NAME OF DECEASED a. (First) ROBERT		b. (Middle) GEORGE	
c. (Last) TROTTER		4. DATE OF DEATH (Month) (Day) (Year) FEB 4 1958	
5. SEX male	6. COLOR OR RACE negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH April 18, 1891
9. AGE (In years last birthday) 66	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	11. BIRTHPLACE (City and State or Foreign Country) MISSISSIPPI	12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME BRASSFIELD		13b. MOTHER'S MAIDEN NAME TROTTER JENNIE MILLS AP	
14. NAME OF HUSBAND OR WIFE ETHEL		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. unk.		17. INFORMANT'S SIGNATURE OR NAME HOSPITAL RECORD ADDRESS KOCH. Mo.	

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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute pneumonia		INTERVAL BETWEEN ONSET AND DEATH 3 days
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) _____		
		DUE TO (c) 490 X		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pneumoconiosis				??

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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

22. I hereby certify that I attended the deceased from **Jan 4, 1958**, to **Feb 4, 1958**, that I last saw the deceased alive on **Feb 4, 1958**, and that death occurred at **9:55 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE Frank Cohen (Degree or title) MD	23b. ADDRESS Robert Koch Hosp Koch Mo	23c. DATE SIGNED 2-6-58
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE Feb 10/58	24c. NAME OF CEMETERY OR CREMATORY Washington Park Cem St Louis Co, Mo	24d. LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG. 2/8/58	REGISTRAR'S SIGNATURE Herbert P. Donke M.D.	25. FUNERAL DIRECTOR'S SIGNATURE F. H. Green ADDRESS 4214 Delmar	

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 F. A. Green.....

Licensed Embalmer No. 2963.....

P. O. Address 4214 Delmonaco.....

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.