

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH 20770-58

58-012422
STATE FILE NUMBER
Registrar's No. 2711

FILED MAR 19 1958

Registration District No. 318 Primary Registration District No. 1003

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-57

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St Charles	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis		c. CITY OR TOWN St Charles	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Saint Louis Maternity		d. STREET ADDRESS (If outside, give location) Elm Point Road	

3. NAME OF DECEASED (Type or print) First Middle Last Trimble			4. DATE OF DEATH Month Day Year March 5 1958		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4 1958	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days Hours Min. 1 6 52	IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St Louis Missouri	12. CITIZEN OF WHAT COUNTRY? --
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13a. FATHER'S NAME Robert Harold Trimble	13b. MOTHER'S MAIDEN NAME Nellie Mae Lowery	14. NAME OF HUSBAND OR WIFE --
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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)	16. SOCIAL SECURITY NO.	17. INFORMANT Nellie Mae Trimble	Address Above
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia Pulmonary Hyaline membrane Maternal diabetes		INTERVAL BETWEEN ONSET AND DEATH 28 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 7691		19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from March 4 1958 to March 5 1958 and last saw ^{her} alive on March 5 1958 Death occurred at 8:12 P M m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) Symon Monat, M.D.	22b. ADDRESS 100 No Euclid	22c. DATE SIGNED 3-6-58
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE MAR 7-1958	23c. NAME OF CEMETERY OR CREMATORY OAK GROVE CEMETERY	23d. LOCATION (City, town, or country) (State) St Charles Mo
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24. FUNERAL DIRECTOR C. L. Trimmer	ADDRESS St Charles Mo	25. DATE RECD. BY LOCAL REG. MAR 6 '58	26. REGISTRAR'S SIGNATURE Carl Smith MD
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use any standard nomenclature when reporting cause of death. All diseases in Part I must be causally related.

Body not embalmed

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 *J. Hall*
Licensed Embalmer No.
P. O. Address

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.