

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-031307

STATE FILE NUMBER

FILM SEP 12 1958 Registration District No. 317 Primary Registration District No. 547 Registrar's No. 2256

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Richmond Heights</b>		c. CITY OR TOWN <b>Warson Woods</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hosp.</b>		d. STREET ADDRESS <b>1659 Dearborn</b>	
Length of stay in 1b <b>1 Day</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>Beatrice</b> Last <b>Trower</b>			4. DATE OF DEATH Month <b>August</b> Day <b>28</b> Year <b>1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 28, 1906</b>	9. AGE (In years last birthday) <b>52</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>Chillicothe, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>C. Oscar Hatcher</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>			

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>487 42 0212</b>	17. INFORMANT <b>W.W. Trower</b>	Address <b>1659 Dearborn Dr. Warson woods, 22, Mo.</b>
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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) <b>Massive Subarachnoid</b> DUE TO (b) <b>Hemorrhage</b> DUE TO (c) <b>330X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>about 4 hrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>(Brain not yet rechecked - no sign of injury)</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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.) <b>No evidence of injury</b>	
20c. TIME OF INJURY Hour <b>2:40</b> Month <b>8</b> Day <b>28</b> Year <b>1958</b> a. m. <b>p.</b>		
20d. INJURY OCCURRED WHILE AT WORK <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

21. I attended the deceased from <b>8/28/58</b> to <b>8/28/58</b> and last saw her/him alive on <b>8/28/58</b> Death occurred at <b>2:40 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <b>Edward J. Simella M.D.</b>	22b. ADDRESS <b>3720 Washington Ave</b>	22c. DATE SIGNED <b>8/28/58</b>

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>8-29-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Chillicothe Cemet.</b>	23d. LOCATION (City, town, or county) (State) <b>Chillicothe, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Gordon, Chillicothe, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>8-29-58</b>	26. REGISTRAR'S SIGNATURE <b>Herbert R. Dombke M.D.</b>

(Licensed Embalmer's Statement on Reverse Side)

Health, & Welfare Public Service

300 1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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

MEDICAL CERTIFICATION

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 *Flouissant*

Licensed Embalmer No. *45*

P. O. Address *Flouissant*

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.