

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-012797

STATE FILE NUMBER

APR 29 1959 Registration District No. 098 Primary Registration District No. Registrar's No. 42

300  
1-57

Dr. J. W. ...

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY Daviess		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Daviess	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Jamesport		c. CITY OR TOWN Jamesport	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in lb 8 Yrs.	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN CURTIS TROXEL		4. DATE OF DEATH Month Day Year April 21 1959	
5. SEX Male <input checked="" type="checkbox"/>	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 14 1877
9. AGE (In years last birthday) 81		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	11. BIRTHPLACE (City and state or country) Daviess Co. Missouri
13a. FATHER'S NAME Martin Alex Troxel		13b. MOTHER'S MAIDEN NAME Lydia A. Brown	
14. NAME OF HUSBAND OR WIFE Artie Louisa Troxel		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs. Doyle Kimes, Jamesport, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Epilepsy</u> DUE TO (b) <u>Interasphyxia</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>5 yrs</u>
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.) 334x	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		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, store, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>Jan 59</u> to <u>4-21-59</u> and last saw him alive on <u>4-21-59</u> Death occurred at <u>4:30 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Signature or title) <u>Clayton E. Helms</u>		22b. ADDRESS <u>Gallatin, Mo</u>	
22c. DATE SIGNED <u>4-22-59</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>4-23-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Scotland Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Daviess Co. Missouri</u>		23e. DATE RECD. BY LOCAL REG. <u>4-25-59</u>	
24. FUNERAL DIRECTOR <u>Hope Funeral Home, Gallatin, Mo.</u>		26. REGISTRAR'S SIGNATURE <u>Vernon Engelhart</u>	

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 *L. O. Richardson* .....

Licensed Embalmer No. *3392* .....

P. O. Address *Holladay, TN* .....

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.