

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-016749

STATE FILE NUMBER

FILED MAY 18 1959 Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 219

1. PLACE OF DEATH a. COUNTY <i>Boone</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Pennicott</i>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Columbia</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>Hayti</i>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Univ. of. med. Cen.</i>		Length of stay in lb <i>2 da</i>		d. STREET ADDRESS <i>Route 1, Box 370</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Michael</i> Middle <i>Wayne</i> Last <i>Trotter</i>				4. DATE OF DEATH Month <i>May</i> Day <i>8</i> Year <i>1959</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>May 6 1959</i>	9. AGE (In years last birthday)	10. UNDER 1 YEAR Months <i>2</i> Days	11. IF UNDER 24 HRS. Hours Min.	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
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) <i>Columbia, Mo.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13a. FATHER'S NAME <i>David Trotter</i>			13b. MOTHER'S MAIDEN NAME <i>Mary Loyd</i>			14. NAME OF HUSBAND OR WIFE	
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 <i>Mother</i> Address <i>same as above</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIAC FAILURE</i>						INTERVAL BETWEEN ONSET AND DEATH <i>30 MIN.</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>PREMATURITY (24 Weeks)</i>						DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						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.) <i>7735</i>				
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
20e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20f. CITY, TOWN, OR LOCATION		COUNTY		STATE
21. I attended the deceased from <i>5-6-59</i> to <i>5-8-59</i> and last saw <sup>her</sup> him alive on <i>5-8-59</i> Death occurred at <i>1:00 p.m.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>Gerard John Seeman M.D.</i> (Degree or title)				22b. ADDRESS <i>Univ. Hosp Columbia</i>			22c. DATE SIGNED <i>5/8/59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>May 11, 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Univ. Medical Center</i>		23d. LOCATION (City, town, or county) (State) <i>Columbia, Missouri</i>		
24. FUNERAL DIRECTOR <i>M. D. Orsholm</i> ADDRESS <i>Mo. &amp; Fall Anatomical Board Columbia, Mo.</i>				25. DATE RECD. BY LOCAL REG. <i>May 11 1959</i>		26. REGISTRAR'S SIGNATURE <i>Mrs R E Palmer</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

**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 .....

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.