

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028411

FILED VS SEP 15 1959

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3010

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STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <b>Cape Girardeau</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Cape Girardeau</b>		a. STATE <b>Missouri</b> COUNTY <b>Cape Girardeau</b>		c. CITY OR TOWN <b>Cape Girardeau</b>	
Length of stay in lb <b>50 years</b>		c. CITY OR TOWN <b>Cape Girardeau</b>		d. STREET ADDRESS (If outside, give location) <b>309 South Westend Blvd</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>309 South Westend Blvd</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>309 South Westend Blvd</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <b>CLARENCE</b>		Middle <b>E.</b>		Last <b>TROVILLION</b>		Month Day Year <b>September 4, 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11/12/1890</b>	9. AGE (last birthday) <b>68</b>	IF UNDER 1 YEAR Months Days <b>9 23</b>		IF UNDER 24 HR Hours Min. <b>0 0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Edge trimmer, ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shoe Factory</b>		11. BIRTHPLACE (City and state or country) <b>Brownfield, Illinois</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S.</b>	
13a. FATHER'S NAME <b>Wm Newton Trovillion</b>			13b. MOTHER'S MAIDEN NAME <b>India Slinkard</b>		14. NAME OF HUSBAND OR WIFE <b>Gertrude M. Trovillion</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>490-05-5500</b>		17. INFORMANT Address <b>Mrs. Gertrude Trovillion Cape Gir., Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b>	
IMMEDIATE CAUSE (a) <b>Melastatic carcinoma</b>							
DUE TO (b) <b>Carcinoma of rectum</b>							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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.)			
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year							
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>Mar 59</b> , to <b>4 Sep 59</b> , and last saw him alive on <b>4 Sep 59</b> Death occurred at: <b>7:40 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Lloyd V. Ashley, M.D.</b>				22b. ADDRESS <b>Cape Girardeau Mo.</b>		22c. DATE SIGNED <b>8 Sep 59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Sept. 8, 1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fairmount Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Cape Girardeau, Missouri</b>	
24. FUNERAL DIRECTOR <b>Walther's Funeral Home</b>		ADDRESS <b>Cape Gir., Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>9-12-59</b>		26. REGISTRAR'S SIGNATURE <b>Drew Koster</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Virgil W. Kelch

Licensed Embalmer No. 4102

P. O. Address Cape Girardeau

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.