

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 23 1959

59-038165

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 9330** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Length of stay in lb 30 Years c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hospital Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY _____ c. CITY OR TOWN St. Louis 12, Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 5880 Enright Ave. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last MRS. EMMA BARBARA TROTTER			4. DATE OF DEATH Month Day Year October 10, 1959								
5. SEX F.	6. COLOR OR RACE W.	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/17/1871	9. AGE (last birthday) 88	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (City and state or country) Liberty, Illinois		12. CITIZEN OF WHAT COUNTRY USA					
13a. FATHER'S NAME Steve Nations			13b. MOTHER'S MAIDEN NAME Jane Wycle			14. NAME OF HUSBAND OR WIFE Dr. Otis Trotter					
15. WAS DECEASED EVER IN U.S. ARMED SERVICES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None			17. INFORMANT Address (30) Mrs. E. W. Clegg 7100 Amherst Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Intertrochanteric fracture left femur DUE TO (c) 900.0 21 INTERVAL BETWEEN ONSET AND DEATH 17 hours 48 hours											
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input checked="" 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.) fell on stairs at home.							
20c. TIME OF INJURY Hour _____ a.m. _____ b.m. _____ 10-8-59		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 053 home		20f. CITY, TOWN, OR LOCATION COUNTY STATE St. Louis, MO.					
21. I attended the deceased from 10-8-59 to 10-10-59 and last saw her alive on 10-10-59 Death occurred at 3:25 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) W. Edward Lamsche, M.D.				22b. ADDRESS 41 North Central, Clayton, Mo.		22c. DATE SIGNED 10/10/59					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal Auto		23b. DATE 10/13/1959		23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		23d. LOCATION (City, town, or county) (State) Camp Point, Illinois					
24. FUNERAL DIRECTOR ADDRESS Alexander & Sons 6175 Delmar Blvd.				25. DATE RECD. BY LOCAL REG. 10-12-1959		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.					

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

J. E. McCulloch

Licensed Embalmer No. 2460

P. O. Address 6. 708 10th

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.