

MISSOURI DIVISION OF PUBLIC HEALTH AND WELFARE - STANDARD CERTIFICATE OF DEATH

REGISTRATION DISTRICT NO. 318; PRIMARY REGISTRATION DISTRICT NO. 1003; REGISTRAR'S NO. 8854 - 61-035057 STATE FILE NUMBER

AMENDED
DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

Registration District No. 318; Primary Registration District No. 1003; Registrar's No. 8854 - 61-035057 STATE FILE NUMBER

FILED OCT 13 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis,</u>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4910 West Pine, Apt 330</u>		d. STREET ADDRESS (If outside, give location) <u>4910 West Pine, Apt 330</u>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>PRENTISS</u> Middle <u>S.</u> Last <u>TROWBRIDGE</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>23rd.</u> Year <u>1961</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-24-1878</u>
9. AGE (last birthday) <u>83</u>		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) <u>Retd. Vice Pres & Gen. Mgr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hydraulic Press Brick</u>	11. BIRTHPLACE (City and state or country) <u>Lee Summit, Ill.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Sabin Hatch Trowbridge</u>	
13b. MOTHER'S MAIDEN NAME <u>Katalina Clapp</u>		14. NAME OF HUSBAND OR WIFE <u>Late Alice B. Trowbridge</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	17. INFORMANT <u>Mrs. Edna R. Bland-340 Page Ave. W.G. 19, Mo.</u>
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>Chronic Renal Insufficiency</u> DUE TO (b) <u>Chronic myocardial Failure</u> DUE TO (c) <u>Arteriosclerosis, generalized</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>422.1</u>		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 <u>1955</u> to <u>Present</u> and last saw him alive on <u>9-15-61</u> Death occurred at <u>5:30 P.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Dr Maxwell MD</u> (Degree or title)		22b. ADDRESS <u>4500 Olive St.</u>	22c. DATE SIGNED <u>9-25-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sept. 26, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St Matthews Cem.</u>	23d. LOCATION (City, town, or county) <u>St. Louis, Mo.</u>
24. FUNERAL DIRECTOR <u>Kriegshauser-4228 S. Kingshighway Blvd.</u>		25. DATE RECD. BY LOCAL REG. <u>SEP 25 1961</u>	26. REGISTRAR'S SIGNATURE <u>Loed Smith MD</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 William B White

Licensed Embalmer No. 4291

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.