

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-003110

STATE FILE NUMBER

AMENDED

Registration District No. 275 Primary Registration District No. 3053 Registrar's No. 10

FILED JAN 23 1962

1. PLACE OF DEATH a. COUNTY PHELPS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY CRAWFORD	
b. CITY (If outside corporate limits, give TOWNSHIP only) ROLLA		Length of stay in 1b 5 DAYS	c. CITY OR TOWN CUBA
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION PHELPS Co. Hosp.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First STELLA Middle L. Last TROTTER			4. DATE OF DEATH Month JAN Day 14 Year 1962				
5. SEX F	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1890	9. AGE (last birthday) 71	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) STEELVILLE Mo		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME WILLIAM WILSON		13b. MOTHER'S MAIDEN NAME OLLIE KEY		14. NAME OF HUSBAND OR WIFE HERSCHEL S. TROTTER			

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.		17. INFORMANT H.S. TROTTER CUBA Mo.		Address	
---	--	-------------------------	--	---	--	---------	--

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Acute Myocardial Infarction		10 min	
DUE TO (b) Coronary Atherosclerosis		20 yrs	
DUE TO (c)			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Bronchial Asthma & Pneumonia			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 Sept 1960 to Jan 14, 1962 and last saw him/her alive on Jan 13, 1962	
Death occurred at 12:55 PM on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE Frank A. Elders M.D.	(Degree or title)	22b. ADDRESS Cuba, Mo.	22c. DATE SIGNED 1-15-62
---	-------------------	----------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 1-16-62	23c. NAME OF CEMETERY OR CREMATORY MT. LEBANON	23d. LOCATION (City, town, or county) (State) ST. LOUIS Co. Mo
--	-----------------------------	--	--

24. FUNERAL DIRECTOR Paul Shank	ADDRESS Cuba, Mo	25. DATE RECD. BY LOCAL REG. Jan. 15, 1962	26. REGISTRAR'S SIGNATURE Nadene L. Stall
---	----------------------------	--	---

(Licensed Embalmer's Statement on Reverse Side)

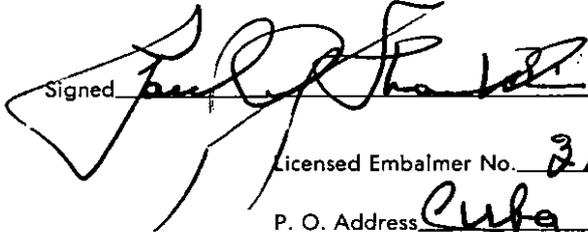
DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

FEB 6 1962

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. 3472
P. O. Address Cuba, Mo.

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.