

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-042138

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10061

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED OCT 17 1963

a. COUNTY <u>St. Louis, Missouri</u>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ILLINOIS</u> COUNTY <u>MADISON</u>		c. CITY OR TOWN <u>GODFREY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <u>ISABELL ST.,</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>NORMAN E. TROWBRIDGE</u>				4. DATE OF DEATH Month Day Year <u>OCTOBER 9, 1963</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>WHITE</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9/5/1910</u>		9. AGE (last birthday) <u>53</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES ENGINEER - HOFFMAN-MARQUARD CO.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MOZIER, ILL.</u>		11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>WILLIAM E. TROWBRIDGE</u>				13b. MOTHER'S MAIDEN NAME <u>SUSAN BARNES</u>				14. NAME OF HUSBAND OR WIFE <u>DOROTHY 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.		17. INFORMANT Address <u>DOROTHY TROWBRIDGE, GODFREY, ILL.</u>					
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>										INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>intraoperative bleeding (post-operative)</u>										<u>6 hrs</u>	
DUE TO (c) <u>arterio iliac thrombosis</u>										<u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>454L</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 checked="" type="checkbox"/> NO <input 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 s.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>October 6, 1963</u> to <u>October 9, 1963</u> and last saw her/him alive on <u>October 9, 1963</u> Death occurred at <u>4:45 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) <u>James M. Stokes M.D.</u>						22b. ADDRESS <u>BARNES HOSPITAL</u>			22c. DATE SIGNED <u>10-9-63</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)					
<u>BURIAL</u>		<u>10/12/63</u>		<u>VALHALLA MEMORIAL PK.</u>		<u>GODFREY, ILLINOIS.</u>					
24. FUNERAL DIRECTOR <u>RALPH A. GENT ALTON, ILL.</u>				25. DATE RECD. BY LOCAL REG. <u>OCT 10 1963</u>		26. REGISTRAR'S SIGNATURE <u>Joan Smith, M.D.</u>					

JAN 10 1964

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 Charles R. McSorley

Licensed Embalmer No. 4852

P. O. Address Alton, Ill

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.