

STANDARD CERTIFICATE OF DEATH

19640

State File No. _____

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 1125

1. PLACE OF DEATH:

(a) County St. Louis County
(b) City or town Jefferson Barracks, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Veterans Administration Facility
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Admitted 5/2/40
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County _____
(c) City or town East St. Louis
(If outside city or town limit, write "RURAL")
(d) Street No. 724 North 15th Street
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 11th
year 1940 hour 11:45 minute _____ a.m.

21. I hereby certify that I attended the deceased from
May 2, 1940 19 _____ to June 11, 1940
that I last saw him alive on June 11, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerosis, generalized, severe, with cerebral involvement, right hemiplegia and motor aphasia. Unkn.

Due to _____
Due to _____
Other conditions none.
(Include pregnancy within 3 months of death)

Major findings:
Of operations No operation.
Of autopsy No autopsy.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) NO
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature C. W. HUGHES, M.D. (Specify type of place) _____
While at work? _____ (e) Means of injury _____
Address Ch. Med. Off., Vet. Adm. Facility, Jefferson Barracks, Missouri.

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

3. (a) PRINT FULL NAME Don C. Trotter 636

3. (b) If veteran, name war Spanish-American 3. (c) Social Security No. Unavailable

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Nov. 5 1878
(Month) (Day) (Year)

8. AGE: Years 61 Months 6 Days 6 If less than one day _____ hr. _____ min.

9. Birthplace Wayne County Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Painter

11. Industry or business _____

12. Name Jehus Trotter

13. Birthplace Hamilton County Illinois
(City, town, or county) (State or foreign country)

14. Maiden name Cynthia Adams

15. Birthplace Hamilton County Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant M. Schilling
(b) Address Clinical Clerk, J.VAF, Jeff. Bks., Mo

17. (a) Removal (b) Date thereof 6-12-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation East St. Louis, Ill.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) JUN 12 1940 (b) R. M. Hughes
(Date received local registrar) (Registrar's signature)

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 _____

Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Licensed Embalmer No. 1861

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 this body is not embalmed, above space should be left blank.

SI JUL