

REGISTRATION DISTRICT NO. 791Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
5640 Cates Avenue
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
13 years
 In this community _____
 years, months or days)

3. (a) PRINT FULL NAME ROY PORTER TROMP3. (b) If veteran World War name was World War 3. (c) Social Security No. 494-10-644. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married6. (b) Name of husband or wife Maxine Tromp 6. (c) Age of husband or wife if alive 34 years7. Birth date of deceased March 30 1896
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
44 4 22 hr. min.9. Birthplace Canal Fulton Ohio
(City, town, or county) (State or foreign country)10. Usual occupation PETROLEUM ENGINEER

11. Industry or business _____

MOTHER FATHER { 12. Name Wm. Tromp
13. Birthplace unknown
(City, town, or county) (State or foreign country)MOTHER FATHER { 14. Maiden name Belle Porter
15. Birthplace unknown
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Mrs. Maxine Tromp
(b) Address 5640 Cates Avenue17. (a) burial (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Lake Charles18. (a) Signature of funeral director Alexander & Sons Inc.
(b) Address 6175 Delmar Blvd.19. (a) AUG 23 1940 (b) J. P. [Signature]
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 5640 Cates Ave.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 22nd
99 year 1940 hour 9 A.M. minute _____ M.21. I hereby certify that I attended the deceased from August 14 1939
_____, 19____, to Aug 22nd, 1940,
that I last saw him alive on Aug 21st, 1940,
and that death occurred on the date and hour stated above.Immediate cause of death Primary Carcinoma of the lung metastasizing to neck glands, liver, spine, pleura
Due to _____
Due to _____Other conditions
(Include pregnancy within 3 months of death)Major findings:
Of operations _____

Of autopsy _____

Duration

one year

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following: No

(a) Accident, suicide, or homicide (specify) _____
 (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?

While at work? _____ (Specify type of place)
(e) Means of injury _____23. Signature Wm W Myers M.D. (M. D. or other)
Address 319 University Club Date signed 8-22-40

Dr. Dan Myers
607 N. Broad
PO 1324

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 J. Wm. Dinkley
Licensed Embalmer No. 3653
P. O. Address St. Louis 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 this body is not embalmed, above space should be left blank.