

No. 2
4-13-40
5-17-39
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FILED APR 21 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

8781
2191

State File No.

Registrar's No.

Registration District No. 7911

Primary Registration District No.

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

1. PLACE OF DEATH:
(a) County: ST. LOUIS
(b) City or town: ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: DE PAUL HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 1 DAY
(Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME: CHARLES P. TROLL

3. (b) If veteran, name war: WORLD WAR #1 3. (c) Social Security No: 489-03-7271

4. Sex: M 5. Color or race: W 6. (a) Single, married, divorced: UNMARRIED

6. (b) Name of husband or wife: LUCILLE H. TROLL 6. (c) Age of husband or wife if alive: 42 years

7. Birth date of deceased: 9-7-1895
(Month) (Day) (Year)

8. AGE: Years: 45 Months: 6 Days: 0 If less than one day: hr. min.

9. Birthplace: ST. LOUIS, MO.
(City, town, or county) (State or foreign country)

10. Usual occupation: OFFICE MAN

11. Industry or business: CURLEE CLOTHING CO.

12. Name: FRANK J. TROLL

13. Birthplace: ST. LOUIS, MO.
(City, town, or county) (State or foreign country)

14. Maiden name: CHARLENE DELANEY

15. Birthplace: MISSISSIPPI
(City, town, or county) (State or foreign country)

16. (a) Informant: LUCILLE H. TROLL
(b) Address: 5260 MAFFETT AVE

17. (a) BURIAL (b) Date thereof: 3-10-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: CALVARY CEMETERY

18. (a) Signature of funeral director: SULLIVAN BROS
(b) Address: 2849 N. EVELL AVE
19. (a) MAR 9 1941 (b) J. T. Bredeh
(Date received local health officer) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State: MO (b) County: 0006
(c) City or town: ST. LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No.: 5260 MAFFETT AVE
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: MARCH day: 7th year: 1941 hour: 7:30 minute: _____ P. M.

21. I hereby certify that I attended the deceased from: 9/11/37 to: 3/7/41 19____; that I last saw him alive on: 3/7/41 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: CEREBRAL HEMORRHAGE (MASSIVE) Duration: 5 1/2 HRS

Due to: ARTERIAL HYPERTENSION (ESSENTIAL) 3 1/2 YRS

Other conditions: _____ (Include pregnancy within 3 months of death)

Major findings: _____ Of operations: _____ Of autopsy: _____ PHYSICIAN: _____ Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(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) Means of injury: _____

23. Signature: Earl Smith M.D. (M. D. or other) Address: 2627 N. Kingshighway Date signed: 3/8/41

JAN 16 1945

QF 6,114

2627 No Kingsbury Hwy
SAL
JAN 23 42
2-5 pm

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 *Albert Mayfield*

Licensed Embalmer No.....

3077

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, fact should be so stated above.