No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29601

FILED AUG 21 1947 #66

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 7692

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis City Hospital-Max C. Starkloff
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 1819a S. Broadway 9
Memorial (If rural, give location) 0
(e) Citizen ~~of foreign~~ 23 country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME JAMES TROXEL
3. (b) If veteran, name war No
3. (c) Social Security No. None
4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Divorced
6. (b) Name of husband or wife Bertha Troxell
6. (c) Age of husband or wife if alive 62 years
7. Birth date of deceased 9 - ~~About~~ 15 - ~~1882~~ 1870
(Month) (Day) (Year)

8. AGE: 76 Years ~~About 85~~ Months 10 Days 27 If less than one day hr. min.
9. Birthplace Alabama 1
(City, town, or county) (State or foreign country)
10. Usual occupation Retired
11. Industry or business Sawmill Operator
FATHER
12. Name Eli Troxell 9
13. Birthplace Unknown 1
(City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Unknown 9
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
16. (a) Informant Myrtle Voris
(b) Address #12 Ridgetop
17. (a) Burial (b) Date thereof 8-14-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Ironton, Mo.
18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.
19. (a) AUG 13 1947 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 12th
year 1947 hour 5:05 minute A M.
21. I hereby certify that I attended the deceased from 8/10/47
2 19 to Aug. 12th 1947
that I last saw him alive on Aug. 12th 1947;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebro-vascular accident, Cerebral hemorrhage	2 days
Due to: Arteriosclerotic Cardiovascular disease	
Due to: Hypertension	years
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN
Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury
23. Signature Joseph E. Hoppe 1515 Lafayette (Sr. D. or other) 8/12/47
Address Date signed

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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.....

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.