

FILED OCT 6 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32453

BIRTH NO. 69608-49 REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3069 Registrar's No. 4030

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

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>020</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Richmond Heights</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u> <u>17</u>	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) <u>5846 Page Ave.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Mary's</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Infant</u> b. (Middle) <u>Troll</u> c. (Last) <u>Troll</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>9/28/49</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u>	8. DATE OF BIRTH <u>Sept 28, 1949</u>
9. AGE (In years last birthday) <u>0</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>23</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>23</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>
			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>

13a. FATHER'S NAME <u>Charles P. Troll</u>	13b. MOTHER'S MAIDEN NAME <u>Norma Jean Rains</u>	14. NAME OF HUSBAND OR WIFE <u>none</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Charles P. Troll</u> ADDRESS <u>5846 Page Ave.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonia Bact.</u>		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>6 months</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Pulmonary tuberculosis.</u>		<u>762.5</u>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>762.5</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-28, 1949, to 9-28, 1949, that I last saw the deceased alive on 9-28, 1949, and that death occurred at 9:28 P m., from the causes and on the date stated above.

23a. SIGNATURE <u>Robert M. D. V.</u> (Degree or title)	23b. ADDRESS <u>Clinton Kelly</u>	23c. DATE SIGNED <u>9-29</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>9/29/49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>9-29-49</u>	REGISTRAR'S SIGNATURE <u>Robert R. Hombickler</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>James J. Quinn</u> ADDRESS <u>1389 Union Blvd.</u>
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(Licensed Embalmer's Statement on Reverse Side)

6-A

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.

Signed _____

No Embalming

Signed _____
Student Embalmer

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.