

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 27806

FILED SEP 8 1950

BIRTH NO. _____		REG. DIST. NO. <u>278</u>		PRIMARY REG. DIST. NO. <u>3054</u>		Registrar's No. <u>90</u>				
1. PLACE OF DEATH a. COUNTY <u>Pike</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Pike</u>						
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Louisiana</u>		c. LENGTH OF STAY (In this place) <u>29 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Louisiana</u> <u>0871</u>						
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1112 Tennessee Street</u>				d. STREET ADDRESS (If rural, give location) <u>1112 Tennessee Street</u>						
3. NAME OF DECEASED a. (First) <u>Clara</u> (Type or Print)			b. (Middle) <u>Elwell</u>		c. (Last) <u>Trotman</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>August 26, 1950</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> <u>2</u>		8. DATE OF BIRTH <u>Sept. 7, 1865</u>	9. AGE (In years last birthday) <u>84</u>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HRS. Hours	IF UNDER 1 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13a. FATHER'S NAME <u>Herbert Elwell</u>			13b. MOTHER'S MAIDEN NAME <u>Ann Watkins</u>		14. NAME OF HUSBAND OR WIFE <u>Dr. Charles A. Trotman</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Dr. R. L. Andrae, Louisiana, Mo.</u>						
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Myocarditis</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Chronic Arterio Sclerotic Renal Syndrome</u> DUE TO (c) <u>4222</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>2 yrs.</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Acute Cardiac Decompensation</u>							Feb. 49			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>7</u>						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
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) (Min.)		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 <u>Aug. 13, 1950</u> , to <u>Aug. 26, 1950</u> , that I last saw the deceased alive on <u>Aug. 26, 1950</u> , and that death occurred at <u>12:35A</u> from the causes and on the date stated above.										
23a. SIGNATURE <u>Robert L. Andrae M.D.</u> (Degree or title)				23b. ADDRESS <u>216 Georgia St. Louisiana, Mo</u>		23c. DATE SIGNED <u>8-26-50</u>				
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>August 28, 50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Bellfontaine Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>					
DATE REC'D BY LOCAL REG. <u>Aug 27, 1950</u>		REGISTRAR'S SIGNATURE <u>Bernice Collier</u>		374		25. FUNERAL DIRECTOR'S SIGNATURE <u>Haley Mortuary, Louisiana, Mo</u>		ADDRESS		

(Licensed Embalmer's Statement on Reverse Side)

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

NOV 20 1950

NOV 22 1950

Date Received: SEP 5 1950
DISTRICT HEALTH OFFICE #
District File Number 9-50-
Date Filed: SEP 7 1950

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.....

working under my personal supervision.

Student Embalmer No.....

Signed.....

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.