

FILED MAR 12 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

21329-58

58-008176  
State File No.

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>544</u>		Registrar's No. <u>692</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN <u>Kirkwood</u> c. LENGTH OF STAY (in this place) township) <u>5 mins</u> d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>St. Louis</u> c. CITY OR TOWN <u>4000 Allenton</u> d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> e. STREET ADDRESS (If rural, give location) _____			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Infant</u> b. (Middle) _____ c. (Last) <u>TROWER</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Mar 7 1958</u>		5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u>		
7. MARRIED (Specify) <u>NEVER MARRIED</u> WIDOWED, DIVORCED		8. DATE OF BIRTH <u>Mar. 7. 1958</u>		9. AGE (in years last birthday) _____ IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 12 HRS. Hours _____ Min. <u>5</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____ 10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (City and State or Foreign Country) <u>Kirkwood</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>Ray Trower</u> 13b. MOTHER'S MAIDEN NAME <u>Rose Iola Trower</u> 14. NAME OF HUSBAND OR WIFE _____		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Jos. Titter Pacific 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>Nelectasis of lung</u>						INTERVAL BETWEEN ONSET AND DEATH <u>51</u>	
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>762.0</u>							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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>3/7</u> , 19 <u>58</u> , to <u>3/7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/7</u> , 19 <u>58</u> , and that death occurred at <u>11:05</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>W. Becker MD.</u>				23b. ADDRESS <u>Pacific Mo.</u>		23c. DATE SIGNED <u>3/7/58</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE <u>Mar. 8. 1958</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St. Bridgets</u>		24d. LOCATION (City, town, or county) (State) <u>Pacific Mo</u>	
DATE REC'D BY LOCAL REG. <u>3-8-58</u>		REGISTRAR'S SIGNATURE <u>Herbert R. Somber M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. John L. Shibles</u>		ADDRESS <u>Pacific, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

**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..

*not embalmed*

Student.....  
Signature of Student Embalmer

Signed.....  
*Mrs. John L. Thebe*  
*Funeral Director*  
~~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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.**