

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020832

STATE FILE NUMBER

FILED JUN 25 1959

Registration District No. 89 Primary Registration District No. _____ Registrar's No. 36

S. 300
V. 1-57

1. PLACE OF DEATH a. COUNTY DeKalb			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo, b. COUNTY DeKalb		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fairport, 3 Mi, S.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Fairport		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION HOME 3 Mi, S.		Length of stay in 1b Life	d. STREET ADDRESS (If outside, give location) 327		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) William Leonard Troxel			4. DATE OF DEATH Month 6- Day 9 Year 59		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan, 6, 1869	9. AGE (In years of birthday) 90	IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (City and state or country) Ohio, 1	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Levi Troxel		13b. MOTHER'S MAIDEN NAME Elizabeth Hipp		14. NAME OF HUSBAND OR WIFE none	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Howard Troxel Address Fairport Mo	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u><i>Senility</i></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u><i>10 yrs</i></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u><i>794X</i></u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u><i>Mar. 19 44</i></u> to <u><i>June 9 1959</i></u> and last saw him alive on <u><i>6-9-59</i></u> Death occurred at <u><i>7:30 AM</i></u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u><i>Harold Foster M.D.</i></u>			22b. ADDRESS <u><i>Maysville MO</i></u>		22c. DATE SIGNED <u><i>6-11-59</i></u>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-12-59	23c. NAME OF CEMETERY OR CREMATORY Fairport		23d. LOCATION (City, town, or county) (State) Fairport Mo
24. FUNERAL DIRECTOR <u><i>Harold Foster</i></u>		ADDRESS Maysville Mo		25. DATE RECD. BY LOCAL REG. 6-26-59	26. REGISTRAR'S SIGNATURE <u><i>Russell Dawson</i></u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

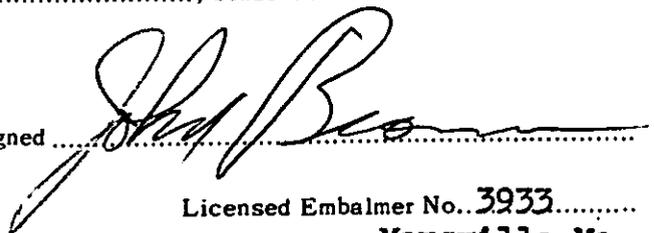
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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.

Student
Signature of Student Embalmer

Signed 

Licensed Embalmer No. **3933**.....
P. O. Address **Maysville Mo**.....

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.