

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-008853

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

2723

FILED MAR 15 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY St Louis			
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St Louis		Length of stay in 1b	c. CITY OR TOWN Chesterfield		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Bapt			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Petzold Rd		
3. NAME OF DECEASED (Type or print) Jeffrey Keith Trower			First	Middle	Last	
4. DATE OF DEATH Mar 9 1962			Month	Day	Year	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/9/1962	9. AGE (last birthday)	IF UNDER 1 YEAR Months Days	
					IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) St Louis Mo	
12. CITIZEN OF WHAT COUNTRY USA			13a. FATHER'S NAME Donald Trower			
13b. MOTHER'S MAIDEN NAME Evelyn Meyer			14. NAME OF HUSBAND OR WIFE -----			
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 Donald Trower Chesterfield 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) Bilateral atelectasis					INTERVAL BETWEEN ONSET AND DEATH ---	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Congenital absence of diaphragm						
DUE TO (c) 756.2						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 Month, Day, Year a.m. p.m.						
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input 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 3/9/62 (3:43 PM) to 3/9/62 and last saw her/him alive on 3/9/62 Death occurred at 6:15 P on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <i>Janet H. M.D.</i> (Degree or title)			22b. ADDRESS 7440 W. Grand St. St. Louis, Mo.		22c. DATE SIGNED 3/10/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3/12/62	23c. NAME OF CEMETERY OR CREMATORY St Monicas Cemetery	23d. LOCATION (City, town, or county) Creve Coeur No		(State)	
24. FUNERAL DIRECTOR Ortmann F Home 9222 Lackland Overland Mo			25. DATE RECD. BY LOCAL REG. MAR 11 1962	REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>		

USE BLACK INK OR TYPEWRITER RIBBON

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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

Not Embalmed
Signed *James Keester*

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.