

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-002097  
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 602

DO NOT WRITE ON THIS STUB

VS 300  
Rev. 4/59

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AMENDED

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF FOWLER

<b>FILED FEB 18 1963</b>	
1. PLACE OF DEATH	
a. COUNTY <u>Jackson</u>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>	a. STATE <u>MO</u> b. COUNTY <u>Jackson</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4123 Independence</u>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
	d. STREET ADDRESS (If outside, give location) <u>4315 Independence</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last	
<u>Eldon Archie Trotter</u>	
4. DATE OF DEATH Month Day Year	
<u>1 - 27 1963</u>	
5. SEX	6. COLOR OR RACE
<u>Male</u>	<u>white</u>
7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH
	<u>2/21/1885</u>
9. AGE (last birthday)	IF UNDER 1 YEAR IF UNDER 24 HR
<u>77</u>	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY
<u>Doctor</u>	<u>Chiropractic Indianapolis, Ind</u>
11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY
<u>Indianapolis, Ind</u>	<u>U.S.A.</u>
13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME
<u>Archie Trotter</u>	<u>Margie</u>
14. NAME OF HUSBAND OR WIFE	Address
<u>Helen Trotter</u>	<u>4315 Indef. Ave</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
<u>no</u>	
17. INFORMANT	Address
<u>Helen Trotter</u>	<u>4315 Indef. Ave</u>
18. CAUSE OF DEATH (Enter only one cause per line)	
PART I. DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (a) <u>Uremia</u>	INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
DUE TO (b) <u>Arteriolar Nephrosclerosis</u>	<u>1 yr</u>
DUE TO (c) <u>Arteriosclerosis</u>	<u>unknown</u>
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 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 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>Jan 63</u> to <u>1-26-63</u> and last saw him alive on <u>1-26-63</u>	
Death occurred at <u>1:30 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title)	22b. ADDRESS
<u>Wm Fowler D.O.</u>	<u>6002 St John</u>
22c. DATE SIGNED	
<u>1-28-63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE
<u>Burial</u>	<u>1-30-63</u>
23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<u>mt. Mish</u>	<u>Kansas City, MO</u>
24. FUNERAL DIRECTOR ADDRESS	25. DATE RECD. BY LOCAL REG.
<u>C.N. Blackman &amp; Son N.C. MO</u>	<u>1-29-63</u>
26. REGISTRAR'S SIGNATURE	
<u>Ruth Long</u>	

USE BLACK INK OR TYPEWRITER RIBBON

Wm. Fowler  
6002 St. John  
New 3 23/13

**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 Bert B. Bennett

Licensed Embalmer No. 4656

P. O. Address H. C., 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.