MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

17106

1. PLACE OF DEATH

County Jackson — Registration District No. 399 — File No. [illegible]

Township Kaw — Primary Registration District No. 1002 — Registered No. [illegible]

City Kansas City (No. 105 W. Armour Blvd. St. Ward)

2. FULL NAME Albert Alexander Trocon

(a) Residence. No. 105 W. Armour Blvd St., 5 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Florence Trocon.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept.6.1864.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
63	8	3	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Civil Engineer.

(c) Name of employer Midland Bridge Co.

9. BIRTHPLACE (CITY OR TOWN) Leavenworth
(STATE OR COUNTRY) Kansas

PARENTS

10. NAME OF FATHER August Trocon.

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) France

12. MAIDEN NAME OF MOTHER Josephine Frache

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) France.

14. INFORMANT Mrs. Florence Trocon,
(Address) 105 W. Armour Blvd.

15. FILED May 9 1928 M. M. Crowe REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/9 1928

17. I HEREBY CERTIFY, That I attended deceased from 1925 June, 1925, to May 9, 1928, that I last saw him alive on May 9, 28, 1928, and that death occurred, on the date stated above, at 12 45 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocarditis. Subacuta

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Diabetes & Chronic Interstitial Nephritis (duration) 3 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? no. DATE OF

WAS THERE AN AUTOPSY? no.

WHAT TEST CONFIRMED DIAGNOSIS? Symptoms X Ray Wrong Forced Beard

(Signed) B. Bishop, M.D.

5/9/ 1928 (Address) 636 Argyle Bldg.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Mt. Moriah	5/10/ 1928
20. UNDERTAKER	**ADDRESS**
H. W. Gates	K.C.Ks.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

B T Sharp