

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

Do not use this space.

18253
2298

1. PLACE OF DEATH

County Jackson Registration District No. _____
 Township North Kansas Primary Registration District No. _____
 City J.C. (No. South West) St. _____ Ward _____

File No. _____
 Registered No. _____

2. FULL NAME

Mrs Minnie Trindle
 (a) Residence. No. _____ St. _____ Ward. North Kansas City Mo
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Geo Trindle

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 26th 1877

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.
	51	7	21	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work. at Home
 (b) General nature of industry, business, or establishment in which employed (or employer). ✓
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____
 (STATE OR COUNTRY) La

10. NAME OF FATHER no data

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) no data

12. MAIDEN NAME OF MOTHER Louise Coukle

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

14. INFORMANT Geo Trindle
 (Address) North Kansas City Mo

15. FILED 7/18/29 M M REGISTRAR
ant

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-17 1929

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ 8:15 P m.

169 THE CAUSE OF DEATH* WAS AS FOLLOWS:
suicide
jumped out hospital
W. H. H. H. H.
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 172
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS _____
 (Signed) Dr. W. H. H. H. H. M. D.

9/17 . 1929 (Address) Liberty Mo

*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 Liberty Mo DATE OF BURIAL 5/19/29 19

20. UNDERTAKER Morton & Co ADDRESS North Kansas City Mo

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.

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