JUL 31 1930

11

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

Do not use this space.

18623

1. PLACE OF DEATH

County Buchanan — Registration District No. 80 — File No.

Township Tremont — Primary Registration District No. 5-120 — Registered No.

City ..... (No. ..... St. ..... Ward)

2. FULL NAME Grace Florence Trotter

(a) Residence. No. ..... St., ... 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)
Female	White	married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF R E Trotter

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 21 1876

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	54	5	16	

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

9. BIRTHPLACE (CITY OR TOWN) Ira Co
(STATE OR COUNTRY) N. Y.

PARENTS

10. NAME OF FATHER W. H. Beach

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

12. MAIDEN NAME OF MOTHER Fannie Lutz

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

14. INFORMANT R E Trotter
(Address) Gower Mo

15. FILED June 8, 1930 Mrs. Lucy Powell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 7 1930

17. I HEREBY CERTIFY, That I attended deceased from May 31, 1930, to June 7th, 1930 that I last saw her alive on June 7th, 19..., and that death occurred, on the date stated above, at 4 25 8 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Embolism
QQB
QQ
(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (SECONDARY) Arteriosclerosis
Did not see her until May 31st 1930 (duration) ..... 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? .....

(Signed) J C Starks, M. D.
, 19 (Address) Gower, 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	DATE OF BURIAL
Mt Moriah	June 9 1930
20. UNDERTAKER	**ADDRESS**
H. A. Sullins	Gower Mo

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

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.