

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

Do not use this space.
38240

PLACE OF DEATH *Livingston*
 County *Livingston* Registration District No. *509*
 Township *Medicine* Primary Registration District No. *5099*
 City *Livingston* (No. *12*) St. *12* Ward

2. FULL NAME *Eberly J. Trumbo*
 (a) Residence. No. *42* St. *12* Ward. *12*
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred *42* yrs. *0* mos. *0* ds. How long in U. S., if of foreign birth? *42* yrs. *0* mos. *0* ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male*
 4. COLOR OR RACE *White*
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *married*
 5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OF (OR) WIFE OF *Anna Trumbo*
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Oct 2-1889*
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
42 1 4
 8. OCCUPATION OF DECEASED *Farmer*
 (a) Trade, profession, or particular kind of work *Farmer*
 (b) General nature of industry, business, or establishment in which employed (or employer) *General farming*
 (c) Name of employer *Liv. Co*

9. BIRTHPLACE (CITY OR TOWN) *Livingston*
 (STATE OR COUNTRY) *Missouri*
 10. NAME OF FATHER *Michael J. Trumbo*
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Liv. Co.*
 (STATE OR COUNTRY) *Missouri*
 12. MAIDEN NAME OF MOTHER *Martha B. McQuade*
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Pennsylvania*
 (STATE OR COUNTRY)

14. INFORMANT *Michael J. Trumbo*
 (Address) *Livingston*
 15. FILED *12-5-31* *O. Boyle*
 REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Nov 6 1931*
 17. I HEREBY CERTIFY, That I attended deceased from *Nov 5, 1931* to *Nov 6, 1931*
 that I last saw *alive* on *Nov 6, 1931*, and that death occurred, on the date stated above, at *9:10 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
fracture at base of skull, accident
thrown from horse
 (duration) *1* yrs. *1* mos. *1* ds.

CONTRIBUTORY (SECONDARY) *None*
 (duration) *0* yrs. *0* mos. *0* 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 *None*
 (Signed) *W. H. Musgrave* M. D.
 , 19 (Address) *Livingston*

*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 *Wallace Cemetery* DATE OF BURIAL *Nov. 8 1931*
 20. UNDERTAKER *Frank R. Smiley* ADDRESS *Livingston*

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.

REC 28 1931

