

EC 151938

REC'D JAN 6 1939

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

44453
Do not use this space.

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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1. PLACE OF DEATH

(a) County St. Louis Registration District No. 784
 (b) Township Cassadaga Primary Registration District No. 105 Registered No. 2041
 (c) City Glendale (d) Street No. 335 N. Berry Rd. St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred 48 yrs. — mos. — ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME H. BURGESS TRIMBLE

(a) Residence, No. 335 N. Berry Rd. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

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) Mollie Williams Trimble

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 22 - 1870

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>68</u>	<u>9</u>	<u>21</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Certified accountant

9. Industry or business in which work was done, as saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) 1921

11. Total time (years) spent in this occupation 30

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wheeling Missouri

FATHER

13. NAME Dr. Robert A Trimble

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Flemmings Co. Kentucky

MOTHER

15. MAIDEN NAME Elizabeth Lester

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Flemmingsburg Kentucky

17. INFORMANT (ADDRESS) Mollie W. Trimble 335 N. Berry Rd.

18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Hill DATE Dec 15 1938

19. FUNERAL DIRECTOR (ADDRESS) Parker Undertaking Webster Groves Mo

20. FILED DEC 15 1938 DR. Meyer M. Bell Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 13 1938

22. I HEREBY CERTIFY, That I attended deceased from Dec 12 1938 to Dec 13 1938
 I last saw him alive on Dec 9 1938 Death is said to have occurred on the date stated above, at 10:30 a.m.
 The principal cause of death and related causes of importance were as follows:

Hemiplegia (Left)
Chr. Myocarditis
Atherosclerosis
Chr. Bronchitis

Other contributory causes of importance: Venous thrombosis

Name of operation None Date of _____
 What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____ (Signed) O. Oberhaugh M. D.
 (Address) 16 No. Gore Ave

Date of onset 1912
15 da

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STATEMENT BY LICENSED EMBALMER

I, Orin B Lang....., Licensed Embalmer No. 1581

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E.

No..... or by....., Registered Apprentice No.....

working under my personal supervision.

Signed: Orin B Lang.....

Licensed Embalmer No. 1581

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.)

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

44453
Do not use this space.

1. PLACE OF DEATH
 (a) County St Louis Registration District No. 784
 (b) Township Glendale Primary Registration District No. 105- Registered No. 204
 (c) City Glendale (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Hunt Burgess Grumble
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>68</u>	<u>9</u>	<u>21</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____

9. Industry or business in which work was done, as saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____

11. Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 13 1938

22. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____

I last saw h. _____ alive on _____ 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Hemiplegia (left) (Date of onset) _____
General paresis
Chronic Carditis
Arterio Sclerosis - Bronchitis
Cerebral

Other contributory causes of importance: acute nephritis

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____ 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) O. P. Seabough, M. D.
 (Address) 1677 Gore ave.

SUPPLEMENT

12. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY)

FATHER

13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY)

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19____

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED _____ 19____

Local Registrar.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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.

