

Registration District No. 17

Primary Registration District No. 4027

Registrar's No. 12

1. PLACE OF DEATH:

(a) County Bates

(b) City or town Adrian, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Main St. Adrian, Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community 4 months
years, months or days

8. (a) PRINT FULL NAME ALVIN TROWBRIDGE

8. (b) If veteran, name war Don't Know

8. (c) Social Security No. Don't Know

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Don't Know

6. (b) Name of husband or wife Don't Know

6. (c) Age of husband or wife if alive Don't Know years

7. Birth date of deceased Nov 22 1871
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>68</u>	<u>5</u>	<u>2</u>	hr. _____ min. _____

9. Birthplace West Maimes Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Don't Know

11. Industry or business 11 11 11

12. Name 11 11 11

18. Birthplace 11 11 Don't Know
(City, town, or county) (State or foreign country)

14. Maiden name Don't Know

15. Birthplace 11 11 11
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Lattie Cummings

(b) Address Adrian, Mo.

17. (a) Crescent Hill (b) Date thereof April 24 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crescent Hill Cemetery

18. (a) Signature of funeral director Creath Hill

(b) Address Adrian, Missouri

19. (a) April 29-40 (b) Ethel C. Stephens
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Iowa (b) County _____

(c) City or town Webster
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 24th
year 1940 hour 6 minute 45 A. M.

21. I hereby certify that I attended the deceased from April 3 -
_____ 1940 to April 24 1940
that I last saw him alive on April 21 1940

and that death occurred on the date and hour stated above.

Immediate cause of death Spinal cord injury

Due to Spinal cord injury

Due to _____

Other conditions Gangrenous ulcers infected
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy no

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence Apr 4 - 1940

(c) Where did injury occur? trans public H.W. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? public H.W.

While at work? no (Specify type of place) (e) Means of injury auto

23. Signature E. E. Rhomms (M. D. or other) _____
Address Adrian Mo Date signed 4-24-40

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

210m
1955

RECEIVED
District Health Officer No. 7,
License Number 5-40-246

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

This Body Not Embalmed

Signed..... *W. A. Dix*
Licensed Embalmer No. *3650*

P. O. Address.....

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.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 14217
Registrar's No. 12

Registration District No. 47

Primary Registration District No. 4027

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Bates
(b) City or town Adrian
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME

Alvin Trowbridge

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced mar

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased

(Month)

(Day)

(Year)

8. AGE:

Years 68

Months 5

Days 2

If less than one day

hr.

min.

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

(City, town, or county)

(State or foreign country)

14. Maiden name

15. Birthplace

(City, town, or county)

(State or foreign country)

16. (a) Informant

(b) Address

17. (a)

(b) Date thereof

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a)

(b)

(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 24
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that I last saw him _____ alive on _____ 19____
and that death occurred on the date and hour stated above

Immediate cause of death Spinal cord injury duration _____

Due to accident auto

Due to 21 PM 27

Other conditions hemorrhage
(Include pregnancy within 3 months of death)

Major findings: fibrous infection

Of operations: collision fire
Of autopsy: object.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Collision
(b) Date of occurrence unknown
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature E. J. Robinson (M. D. or other)
Address Adrian Mo Date signed _____

SUPPLEMENTAL

