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

FILED JUL 12 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Dr Moody

State File No. 21985

Registration District No. 411 Primary Registration District No. 2002 Registrar's No.

1. PLACE OF DEATH:

(a) County Jasper

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

(c) Name of hospital or institution: St Johns Hospital 1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 21 days (Specify whether

In this community 6 yr 11 mo 27 da years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper

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

(d) Street No. 1006 Central (If rural, give location)

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

3. (a) PRINT FULL NAME William D. Trenary 626

3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife ✓ 6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased June (Month) 28, (Day) 1933 (Year)

8. AGE: Years 6 Months 11 Days 27 If less than one day hr. min.

9. Birthplace Joplin (City, town, or county) Mo. 6 (State or foreign country)

10. Usual occupation Child

11. Industry or business 1

FATHER
12. Name Hayden Trenary 6
13. Birthplace Adair (City, town, or county) Okla (State or foreign country)

MOTHER
14. Maiden name Mavis Martin
15. Birthplace Joplin (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Hayden Trenary

(b) Address 1006 Central Joplin Mo.

17. (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 6-26-40 (Month) (Day) (Year)

(c) Place: burial or cremation Ozark Mem. Park

18. (a) Signature of funeral director Pamphen Mortuary

(b) Address Joplin Mo.

19. (a) 6-25-40 (Date received local registrar) (b) Ed D Jones (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 24 year 1940 hour 4:00 minute A M.

21. I hereby certify that I attended the deceased from 2-18-40, 19, to ~~X~~ 6-24-40, 19 that I last saw him alive on 6-24-40, 19 and that death occurred on the date and hour stated above. ✓

Immediate cause of death Maligmant glioma

Due to OPERATED AT BARNES

Due to HOSPITAL? ST. LOUIS?MO BY DR. SACHS

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

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)

(b) Date of occurrence

(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? 372 (Specify type of place)

While at work? (e) Means of injury

23. Signature Elliott Mead (M. D. ~~or other~~) 1

Address Joplin, Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

5th

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.

Signed Howard Farmer

Licensed Embalmer No. 4134

P. O. Address Joplin Mo.

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.

. No. 2B
—2-21-40
I X22659

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21985

Registration District No. 411 Primary Registration District No. 2002 Registrar's No.

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

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Independence
(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 years, months or days)
In this community

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.

3. (a) PRINT FULL NAME: Wm D. Tremary
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: S
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)
8. AGE: Years 6 Months 11 Days 27 If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 24 year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19, to , 19; that I last saw h alive on , 19; and that death occurred on the date and hour stated above.

Immediate cause of death: Malignant Glioma (Duration)
Due to
Due to: operated at Barnes Hospital St Louis Mo
Other conditions (Include pregnancy within 3 months of death): Dr Jack
Major findings:
Of operations
Of autopsy

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)
(b) Date of occurrence
(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: Ethel Moody (M. D. or other)
Address: Independence Mo Date signed

SUPPLEMENTARY