

AUG 10 1940

85

Primary Registration District No. 1001

State File No. _____

Registrar's No. 733

1. PLACE OF DEATH:

(a) County **BUCHANAN**
(b) City or town **ST. JOSEPH**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **STATE HOSPITAL No. 2**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: **3 mos. 11 ds.**
(Specify whether in this community years, months or days) **in hospital, 3 mo. 11 ds.**

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULLNAME **Wm. Trillow 1040**

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 **married**

6. (b) Name of husband or wife **Estelle** 6. (c) Age of husband or wife if alive - **2** years

7. Birth date of deceased **Aug. 2, 1866**
(Month) (Day) (Year)

8. AGE: Years **73** Months **11** Days **6** If less than one day hr. _____ min. _____

9. Birthplace **Unknown Eng. 4**
(City, town, or county) (State or foreign country)

10. Usual occupation **florist 4**

11. Industry or business _____

12. Name **Chas. Trillow 4**

13. Birthplace **Eng. 4**
(City, town, or county) (State or foreign country)

14. Maiden name **Elizabeth Prich 4**

15. Birthplace **Eng. 4**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Liz. Smith**

(b) Address **Montrose Hotel, K.C., Mo.**

17. (a) **Removal - K.C. Mo.** (b) Date thereof **7/8/1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Kansas City, Mo.**

18. (a) Signature of funeral director **John M. Murrin**

(b) Address **1302 Tenth St. St. Joseph, Mo.**

19. (a) **7/8/40** (b) **D. J. Mattlebaum**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **8** / 1940
year _____ hour **9:45** minute **9** A.M.

21. I hereby certify that I attended the deceased from **7/27** 1940 to **7/8** 1940

that I last saw him alive on **7/5** 1940 and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic myocardia 2**

Due to **Arteriosclerosis 2**

Due to _____

Other conditions **Q3P 2**
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy **no autopsy**

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? **85**

While at work? (Specify type of place)

(e) Means of injury _____

23. Signature **J. T. O'Dell** (M. D. or other) **1 mo.**

Address **St. Joseph** Date signed **7/8/40**

Duration
2
2

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

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.....

Oby J. Ester

Licensed Embalmer No. *4154*

P. O. Address *St. Joseph, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.