

No. 2
5-17-39
I X21422

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

25356

AUG 23 1940

State File No.

Registration District No. 400

Primary Registration District No. 5553/2

Registrar's No. 131

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

1. PLACE OF DEATH

(a) County Jackson
(b) City or town Prairie Township
(c) Name of hospital or institution: Jackson County Home for the aged 3
(d) Length of stay: In hospital or institution 3 (Specify whether In this community 3 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
(c) City or town Little Blue
(d) Street No. County Home
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME

Herman Trout 6.30

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 W

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

7. Birth date of deceased: (Month) 7 (Day) 27 (Year) 1863

8. AGE: Years 74 Months 10 Days 27 If less than one day _____ hr. _____ min.

9. Birthplace Ohio (City, town, or county) _____ (State or foreign country) _____

10. Usual occupation Laborer

11. Industry or business Unknown

12. Name Unknown

13. Birthplace Unknown (City, town, or county) _____ (State or foreign country) _____

14. Maiden name Unknown

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

16. (a) Informant Smillion

(b) Address Little Blue

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

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director Hetterling

(b) Address 460 W. 2657 Ind. Pk.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 14 year 1940 hour 4 minute 9 P.M.

21. I hereby certify that I attended the deceased from June 20 1940, 19, to June 24, 1940 that I last saw him alive on June 23, 1940 and that death occurred on the day and hour stated above.

Immediate cause of death Carcinoma of jaw & throat

Due to _____

Due to _____

Other conditions Sec. Anemia (Include pregnancy within 3 months of death)

Major findings: Of operations _____ Of 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? _____

23. Signature W. C. Barton (M.D. or other) _____

Address Little Blue June 24-40

Physician

PHYSICIAN

Underline the cause to which death should be charged statistically.

(Licensed Embalmer's Statement on Reverse Side)

45

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 Wm. Ward

Licensed Embalmer No. 3991

P. O. Address 5725 Virginia

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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 25-356

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 400

Primary Registration District No. 5553 B

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Franklin
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Herman Trout

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 w

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 74 Months 10 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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)
(Date received local registrar)

SUPPLEMENTAL

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. some 24 years.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH: June 14 day _____ year _____ 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: Carcinoma of jaw and throat Dysphagia

Due to: Primary lower jaw bone.

Other conditions: Sec. anemia

(Include pregnancy within 3 months of death)

Major findings: _____
Of operations: 45

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) _____ (Specify means of injury)

23. Signature W. J. Mc Carthy (M. D. or other) _____
Address Little Blue Mo _____

