

FILED OCT 10 1940

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

32035

State File No. \_\_\_\_\_

Registration District No. 318

Primary Registration District No. 2001

Registrar's No. 752

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. John's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 days  
(Specify whether \_\_\_\_\_)  
In this community 7 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene  
(c) City or town Springfield  
(If outside city or town limits, write "RURAL")  
(d) Street No. 934 N. Robberson  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME EPHRIAM FANNEN TROTTER

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

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

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

7. Birth date of deceased April 8, 1867  
(Month) (Day) (Year)

8. AGE: Years 73 Months 5 Days 7 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Christian Co., Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business Farm

12. Name Ephriam O. Trotter

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

14. Maiden name Carol Robberson

15. Birthplace Near St. Louis, Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Almeda Hunt

(b) Address 934 N. Robberson, Springfield, Mo.

17. (a) Burial (b) Date thereof Sept. 17, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation East Lawn

18. (a) Signature of funeral director F. C. Williams

(b) Address Springfield, Mo.

19. (a) Sept. 16, 1940 (b) W. E. Haudley, M.D.  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 15  
year 1940 hour 6:45 minute 1 A. M.

21. I hereby certify that I attended the deceased from 9/12/40  
\_\_\_\_\_ 1940 to 9/15 1940  
that I last saw him alive on 9/14  
and that death occurred on the date and hour stated above.

Immediate cause of death Peritonitis

Due to Ruptured Sigmoid Appendix

Other conditions 121  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Embalmer's Stamp

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? \_\_\_\_\_

904 (Specify type of place) \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place) \_\_\_\_\_

23. Signature W. E. Haudley, M.D. (M. D. or other) M.D.

Address Springfield, Mo. Date signed 9/14/40

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

9  
3  
6

**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 R. H. Thorne

Licensed Embalmer No. 3681

P. O. Address Springfield, Me

**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.

X