

Registration District No. 702

Primary Registration District No. 4422

1. PLACE OF DEATH:

(a) County Polk
(b) City or town Fair Play, Mo.
(If outside city or town limits, write "RURAL" and name of township.)
(c) Name of hospital or institution: Home
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Polk
(c) City or town Fair Play
(If outside city or town limits write "RURAL")
(d) Street No. Rural R #2
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Jonathon James Trimble

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

4. Sex male 5. Color or race W. 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 Feb. 20 1854
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
87 5 3 hr. min.

9. Birthplace Polk Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Green C. Trimble
13. Birthplace Ky.
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Rogers
15. Birthplace N.Y.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs A.A. Hayse
(b) Address Fair Play, Mo.

17. (a) Burial (b) Date thereof July 24-41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Trimble Cemetary

18. (a) Signature of funeral director Frank W. Barker
(b) Address Fair Play, Mo.

19. (a) Oct. 16/41 (b) F. H. Hunt
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23
year 1941 hour 6 minute _____ P. M.

21. I hereby certify that I attended the deceased from Apr 29 to July 23, 1941
that I last saw him alive on July 20, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia
Duration 2 weeks

Due to Prostatic hypertrophy

Other conditions # 137a
(Include pregnancy within 3 months of death)

Major findings: No operation
Of operations _____

Of autopsy None

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 Fair Play Mo (M. D. or other) #
Address _____ Date signed _____

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

84
6
0



11-41-18
11-6-41

RECEIVED

District Health Officer No. 7;

District File Number 11-41-18 //

Date Filed 11-6-41

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.....

Licensed Embalmer No.

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

State File No. 35 890

Registration District No. 702

Primary Registration District No. 4423

Registrar's No.

1. PLACE OF DEATH:

(a) County Talk
(b) City or town Fair Play
(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)

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Jonathan J. Hunt

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 23
Year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____
that I saw him _____ there on _____, 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

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

4. Sex M 5. Color of 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 Feb. 20, 1854
(Month) (Day) (Year)

8. AGE: Years 87 Months 5 Days 5 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry of 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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

Due to _____

Due to _____

Other conditions _____ (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? _____

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

23. Signature Chas. H. Brown (M.D. or other) _____

Address Fair Play Date signed 7/23/41

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

SUPPLEMENTARY 23

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-35810