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DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

BUREAU OF THE CENSUS
DEC 22 1941

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4429

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

1. PLACE OF DEATH:

(a) County Jackson,

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

(c) Name of hospital or institution;
430 West 35th Street,
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution X
(Specify whether years, months or days)

In this community about 50 years,

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri, (b) County Jackson,

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

(d) Street No. 430 West 35th Street,
(If rural, give location)

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

3. (a) PRINT FULL NAME Samuel Trotter,

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

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

6. (b) Name of husband or wife Rosa Louise Trotter 6. (c) Age of husband or wife if alive 30 years

7. Birth date of deceased. June 30 1857
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 28th,
year 1941 hour 11:45 minute A. M.

21. I hereby certify that I attended the deceased from Nov. 10, 1941, to Nov 28, 1941;
that I last saw him alive on Nov 28, 1941;
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

84	4	28	hr. min.
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9. Birthplace Ohio,
(City, town, or county) (State or foreign country)

10. Usual occupation Retired,

11. Industry or business X

Immediate cause of death Angina Pectoris

Due to Chronic Myocarditis - Myocardial degeneration

Due to Emphysema

Other conditions Ch. Interstitial Nephritis
(Include pregnancy within 3 months of death)

MOTHER FATHER {

12. Name Samuel Trotter,

13. Birthplace Edinburgh, A
(City, town, or county) (State or foreign country)

14. Maiden name Jane McCreight,

15. Birthplace Edinburgh, A
(City, town, or county) (State or foreign country)

16. (a) Informant Florence Trotter,

(b) Address 430 West 35th St., Kansas City, Mo

17. (a) Burial, (b) Date thereof 12-1-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cemetery,

18. (a) Signature of funeral director Stine & McClure,

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 11-29-41 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

Major findings: Of operations ✓ 13:12

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 Glenn H. Brayley (M. D. or other) MD
Address 11232 Prof. Bldg Date signed 11-28-41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Dr. Broyles
Pimp Bledy

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.....

Stellis H Bennett, Registered Apprentice No. 282
working under my personal supervision.

Signed E. M. Plank

Licensed Embalmer No. 1848

P. O. Address K. C. 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, fact should be so stated above.