

FILED NOV 9 1942

Registration District No. **316**

Primary Registration District No. **6075**

Registrar's No. **130**

1. PLACE OF DEATH:

(a) County **St. Francois**
(b) City or town **Farmington RURAL St. Francois**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Mo. State Hospital #4 2**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **6 mos. 23 das.**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Mississippi**
(c) City or town **Charleston**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **MINNIE TRAYLER**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **B. U. or Urary Trayler** 6. (c) Age of husband or wife if **28**
7. Birth date of deceased **February 28, 1881**
(Month) (Day) (Year)

8. AGE: Years **61** Months **7** Days **14** If less than one day hr. _____ min. _____

9. Birthplace **Hickman Kentucky**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **James Ashworth**
13. Birthplace **England**
(City, town, or county) (State or foreign country)
14. Maiden name **Nancy Monrowe**
15. Birthplace **Indiana**
(City, town, or county) (State or foreign country)

16. (a) Informant **Records State Hospital No. 4**

(b) Address **Farmington, Mo.**

17. (a) **Burial** (b) Date thereof **Oct. 14, 1942**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Oakgrove Cem., Charleston, Mo.**

18. (a) Signature of funeral director **Nunnlee-Lair Und. Co.**

(b) Address **Charleston, Mo.**

19. (a) **Oct. 16, 1942** (b) **Byrdie Buhmester**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **12**
year **1942** hour **10** minute **15** A.M.

21. I hereby certify that I attended the deceased from **Sept. 10, 1942** to **October 12, 1942**
that I last saw her alive on **October 12, 1942**
and that death occurred on the date and hour stated above.

Immediate cause of death **Psychosis**
Due to **Cerebral Arteriosclerosis**

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? **Mo.**
While at work? _____ (Specify type of place) (e) Means of injury **9**
23. Signature **Otto P. Schudde, M.D.** (M. D. or other) _____
Address **Farmington, Mo.** Date signed **10-19-42**

Duration

1 yr.

2 yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

94

94

0

0

0

0

1146

RECEIVED

District Health Officer No. 3

District File Number 1142-1301

Date Filed 11-5-42

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.....

me, Registered Apprentice No.....
working under my personal supervision.

Signed.....Ch. Cozart

Licensed Embalmer No. 4084

P. O. Address Farmington, 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.