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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 14 1944

Registration District No. 3

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH 3

Primary Registration District No. 5755

State File No. 3388

Registrar's No. 23

1. PLACE OF DEATH:

(a) County: Lawrence

(b) City or town: Mount Vernon Twp (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Missouri State Sanatorium (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 65 days (Specify whether years, months or days)

In this community: 65 days

2. USUAL RESIDENCE OF DECEASED: 50

(a) State: Missouri (b) County: Jefferson 9

(c) City or town: De Soto 9 (If outside city or town limits, write "RURAL")

(d) Street No.: 314 E. Main (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country: /

3. (a) PRINT FULL NAME: Cora Estell Trunk.

3. (b) If veteran, name war: no

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: John L. Trunk

6. (c) Age of husband or wife if alive: 37 years

7. Birth date of deceased: Sept. (Month) 17 (Day) 1909 (Year)

8. AGE: Years: 34 Months: 4 Days: 20 If less than one day: hr. min.

9. Birthplace: De Soto (City, town, or county) Missouri (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business: X

MOTHER FATHER

12. Name: unknown ?

13. Birthplace: unknown (City, town, or county) unknown (State or foreign country)

14. Maiden name: unknown ?

15. Birthplace: unknown (City, town, or county) unknown (State or foreign country)

16. (a) Informant: E. McMichael, Record Clerk

(b) Address: Mo State San., Mount Vernon

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 2-7-44 (Month) (Day) (Year)

(c) Place: burial or cremation: DeSoto Mo.

18. (a) Signature of funeral director: Geo. B. Orr

(b) Address: Mt Vernon Mo

19. (a) 2-9-44 (Date received local registrar) (b) Andy Crawford (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Feb. day: 6 year: 1944 hour: 5 minute: 05 A.M.

21. I hereby certify that I attended the deceased from December 4, 1943 to Feb. 6, 1944 that I last saw him alive on Feb. 5, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Tuberculosis	over 1 yr.
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy:	

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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? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: Esther E. Coffman (M. D.)

Address: Mo State Sanatorium, Mt. Vernon, Mo. Date signed: 2-6-44

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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 244-173
Date Filed FEB 11 1944

SEP 27 1948

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 Geo B Orr

Licensed Embalmer No. 9x6

P. O. Address Mt Vernon Dr

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.