

FILED FEB 14 1944

Registration District No. 377

Primary Registration District No. 3063

Registrar's No. 314

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 0
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Indiana (b) County Posey 999
(c) City or town Wadesville 12
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

William Sherman Trigg

3. (b) If veteran, name war None

3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Widower
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased About 1864
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
About 80 hr. min.

9. Birthplace Unknown South Carolina
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER
12. Name Unknown
13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Wm. Sherman Trigg
(b) Address 7309 Cornelia
17. (a) Removal (b) Date thereof 2-8-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Evansville, Indiana

18. (a) Signature of funeral director Albert HarHoppe, Inc
(b) Address 4700 Washington Blvd.
19. (a) FEB 8 - 1944 (b) C. B. McLawan, MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 5
year 1944 hour about 8 minute P M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion;
cerebral arteriosclerosis;
Senility

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy gpc

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? _____ (c) Means of injury _____
23. Signature J. S. McLawan (M.D. or other) M.D.
Address Indiana Co Health Dept Date signed Feb 7 1944

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

96
2
3

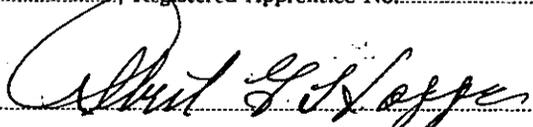
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

.....
working under my personal supervision.

..... Registered Apprentice No.....

Signed.....



..... Licensed Embalmer No..... 2971

..... 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, fact should be so stated above.