

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

Registration District No. Primary Registration District No. 3056

1. PLACE OF DEATH:

(a) County Randolph

(b) City or town Moberly

(c) Name of hospital or institution:  
310 N. Williams  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 yrs  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County RANDOLPH

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

(d) Street No. 310 N. Williams  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Benjamin Trustee

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 23<sup>rd</sup>  
year 1945 hour 4 minute 00 P.M.

21. I hereby certify that I attended the deceased from Feb 20  
1945 to Feb 23 1945  
that I last saw him alive on Feb 23 1945  
and that death occurred on the date and hour stated above.

4. Sex MO 5. Color or race W

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Minerva Trustee

6. (c) Age of husband or wife if alive ✓ years \_\_\_\_\_

7. Birth date of deceased OCT 5 1854  
(Month) (Day) (Year)

Immediate cause of death Apoplexy

Duration 3hr

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years 90 Months 4 Days 18  
If less than one day hr. min.

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

10. Usual occupation Farmer

MOTHER FATHER {

11. Industry or business Farmer

12. Name Willis Trustee

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

14. Maiden name Margaret Hancock

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

16. (a) Informant Luther C. Trustee

(b) Address 223 Bedford, Moberly

17. (a) BURIAL (b) Date thereof 2-25-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oakland (Moberly)

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? \_\_\_\_\_

18. (a) Signature of funeral director E. E. Gupper

(b) Address Blaine, Mo

19. (a) 2-25-45 (b) Benjamin Trustee  
(Date received local registrar) (Registrar's signature)

23. Signature H. Griffith (M. D. or other)  
Address Moberly Mo Date signed 2/25

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

RECEIVED

District Health Officer No. 10

District File Number 2-45-522

Date Filed: MAR 9 1945

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.....

*Louis C. Hopper*

Licensed Embalmer No.....

*426*

P. O. Address.....

*Clarence, 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.