

FILED OCT 13 1945

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4060

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Jackson City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 327 So. Bales 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 1 year  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County L 13  
(c) City or town Breckenridge Mo 0  
(If outside city or town limits, write "RURAL.")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country?  (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Ira Trooper

(b) If veteran, name war 10

(c) Social Security No. N/A

4. MALE 5. Color or race W  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Ira Trooper  
6. (c) Age of husband or wife if alive unk years  
7. Birth date of deceased 11 29 1892  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 1  
year 1945 hour 8 minute A M.  
21. I hereby certify that I attended the deceased from 1st Oct 1st 1945  
that I last saw h. in alive on Sept 25th 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary Tuberculosis

Duration

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

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

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

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

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

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (b) Means of injury \_\_\_\_\_

23. Signature Dr. Joseph Seltzer (M. D. or other) M.D.  
Address 1719 Baults Bldg Date signed 10-1-45

8. AGE: Years 72 Months 10 Days 8 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
9. Birthplace Missouri (State or foreign country)  
10. Usual occupation Retired Farmer  
11. Industry or business \_\_\_\_\_  
12. Name Robert Trooper  
13. Birthplace Mo (State or foreign country)  
14. Maiden name Ann Bennett  
15. Birthplace Mo (State or foreign country)  
16. (a) Informant Ira Trooper  
(b) Address 327 So Bales  
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/1/45 (Month) (Day) (Year)  
(c) Place: burial or cremation Breckenridge Mo  
18. (a) Signature of funeral director STINE-McCLURE  
(b) Address Jackson Mo  
19. (a) 10-2-45 (Date received local registrar) (b) Stearline Holmes (Registrar's signature)

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

MOTHER FATHER

Dr. J. J. Peterson  
P.O. Box 130

**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..... Robert H Reed.....

Licensed Embalmer No. 3743.....

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!**