

STANDARD CERTIFICATE OF DEATH

State File No. **31076**

FILED OCT 9 1945
Registration District No. **277**

Primary Registration District No. **4734**

Registrar's No. **10**

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

1. PLACE OF DEATH:

(a) County **Newton**
(b) City or town **Diamond RR 1 Marion Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Diamond Rt 1 /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community **Life** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jasper 49**
(c) City or town **Joplin 2**
(If outside city or town limits, write "RURAL")
(d) Street No. **806 Jefferson 5**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Mrs Maud Trimble**

3. (b) If veteran, name war **N o.**
3. (c) Social Security No. **497-14-8557**

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Walter T.**
6. (c) Age of husband or wife if alive **64** years

7. Birth date of deceased **June 9 1884**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
61 3 12 hr. min.

9. Birthplace **Neosho Rt 1 Cook**
(City, town, or county) (State or foreign country)

10. Usual occupation **Cook**

11. Industry or business **Roys Barbecue**

MOTHER FATHER {
12. Name **Andrew Jackson Thompson**
13. Birthplace **No Record 9**
(City, town, or county) (State or foreign country)
14. Maiden name **MARIE E Hughes**
15. Birthplace **No Record 9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs A O Horine**
(b) Address **Diamond Rt 1**

17. (a) **Burial** (b) Date thereof **9-24 45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Fairview**

18. (a) Signature of funeral director **Fuelhart Und Co**
(b) Address **Joplin, Mo.**

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **21**
year **1945** hour **9** minute **25 P.M.**

21. I hereby certify that I attended the deceased from **9/17** **1945** to **9/26/1945**
that I last saw her alive on **9/20** **1945**
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinomatosis 1 yr.**
Carcinoma of Right Breast

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

Major findings: Of operations _____
Of autopsy **yes 50**

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) (or) Means of injury _____
23. Signature **[Signature]** (or) D. or other _____
Address **Joplin, Mo.** Date signed **9/22/45**

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.

RECEIVED OCT 3 1945

District Health Officer No.

District File Number 945-179

Date Filed OCT 3 1945

Registered Apprentice No.

Signed *Ferry K. Hurlbut*

Licensed Embalmer No. 959

P. O. Address *Japan Hill*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. out
Registrar's No. 10

Registration District No. 244

Primary Registration District No. 283x

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

1. PLACE OF DEATH:

(a) County Newton

(b) City or town Rural Marion Twp
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days)

3. (a) PRINT FULL NAME Maud Trimble

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race w

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: June 9
(Month) (Day) (Year)

8. AGE: Years 61 Months 3 Days mo
If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 9/29-47 (b) Mrs. Albie Parnell
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Day 1
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____
_____ 19____; that I or my h. _____ arrive on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

Duration _____

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)

(b) 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 _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

31076