

1. PLACE OF DEATH:

(a) County **GRUNDY**  
(b) City or town **TRENTON**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**1806 CHESNUT**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community **6 MONTHS** years, months or days

3. (a) PRINT FULL NAME **SARAH ALICE TROSPER**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **FEMALE** 5. Color or race **NEGRO**  
6. (a) Single, widowed, married, divorced **WIDOWED**  
6. (b) Name of husband or wife **W. ANDERSON TROSPER** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **UNKNOWN**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**about 87** hr. min.

9. Birthplace **DAVIS COUNTY, MISSOURI**  
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSEWIFE**

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name **LUKE BANTON**  
13. Birthplace **UNKNOWN - UNKNOWN**  
(City, town, or county) (State or foreign country)  
14. Maiden name **UNKNOWN**  
15. Birthplace **UNKNOWN**  
(City, town, or county) (State or foreign country)

16. (a) Informant **FRANK TROSPER**  
(b) Address **CHILLICOTHE - MO.**

17. (a) **BURIAL** (b) Date thereof **10-8-46**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **BROOKIN RIPP, MO.**

18. (a) Signature of funeral director **NORMAN FUNERAL HOME**  
(b) Address **CHILLICOTHE, MISSOURI**

19. (a) **10-8-46** (b) **J. H. JAW**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **LIVINGSTON**  
(c) City or town **Chillicothe**  
(If outside city or town limits, write "RURAL.")  
(d) Street No. **120 Lybia**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **5<sup>TH</sup>**  
year **1946** hour **7** minute **35 A.M.**

21. I hereby certify that I attended the deceased from **1944** to **Oct 5** 19 **46**  
that I last saw her alive on **Sept** 19 **46**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic myocarditis**  
Duration \_\_\_\_\_

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

PHYSICIAN  
Major findings: Of operations **93D**  
Of autopsy \_\_\_\_\_  
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) (e) Means of injury \_\_\_\_\_

23. Signature **W. A. Johnson** (M. D. or other) **MD**  
Address **Phinton** Date signed **10-2-46**

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

DISTRICT HEALTH OFFICE  
Cameron, Mo.

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 *Elton J. Norman*

Licensed Embalmer No. *4036*

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.