

S. No. 2
M-5-43
r. 5-17-39
I X36671

FILED DEC 9 1946

State File No. _____

Registration District No. _____ Primary Registration District No. **1003** Registrar's No. **10055**

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis Mo
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution 8 days
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Jefferson 99

(c) City or town Mt. Vernon
(If outside city or town limits, write "RURAL")

(d) Street No. 315 S. 7th St.
(If rural, give location)

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

3. (a) PRINT FULL NAME DOROTHY T Troutt

3. (b) If veteran, name war Nil

3. (c) Social Security No. Unknown

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Glen Troutt

6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased June 23 1907
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 24
year 1946 hour 2 minute 10 A.M.

21. I hereby certify that I attended the deceased from Nov 16 1946 to Nov 24 1946
that I last saw her alive on Nov 24 1946
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>39</u>	<u>5</u>	<u>1</u>	hr. _____ min. _____

Immediate cause of death UREMIA Duration 4 months

Due to CHRONIC GLOMERULO-NEPHRITIS

Due to _____

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

10. Usual occupation Housewife

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

Major findings: Of operations _____

Of autopsy As above

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

11. Industry or business _____

MOTHER FATHER { 12. Name George Garris

{ 13. Birthplace Unknown Unknown 9
(City, town, or county) (State or foreign country)

{ 14. Maiden name Unknown

{ 15. Birthplace Unknown Unknown 9
(City, town, or county) (State or foreign country)

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? _____

16. (a) Informant Mt. Vernon, Ill.

(b) Address Removal

17. (a) (Burial, cremation, or removal) 11-25-46
(Month) (Day) (Year)

(c) Place: burial or cremation Mt. Vernon, Illinois

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) NOV 25 1946 (Date received local registrar)

J. F. Brudeck (Registrar's signature)

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature Glen O. Turner (M. D. or other)

Address Barnes Hospital Date signed _____

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

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.....

Ray W Wilkinson
.....
Licensed Embalmer No. *3574*

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.