

Registration District No. **389**

Primary Registration District No. **5761**

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

1. PLACE OF DEATH:

(a) County **Callaway**

(b) City or town **Rural (Cedar墩)**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
**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 **Life** \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Callaway**

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

(d) Street No. \_\_\_\_\_ (If rural, give location)

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

3. (a) PRINT FULL NAME **Robert. St. Lawrence Trigg**

3. (b) If veteran, name war **No**

3. (c) Social Security No. \_\_\_\_\_

4. Sex **Male** 5. Color or race **White**

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

6. (b) Name of husband or wife **Mary Cassig**

6. (c) Age of husband or wife if alive **77** years

7. Birth date of deceased **Feb-22-1871**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

**76 0 12** hr. \_\_\_\_\_ min.

9. Birthplace **Callaway Co. MO**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer, Coal Business**

11. Industry or business

12. Name **Gabriel H. Trigg**

13. Birthplace **Callaway Co. MO**  
(City, town, or county) (State or foreign country)

14. Maiden name **Josephine Smith**

15. Birthplace **Callaway Co. MO**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Earl Trigg**

(b) Address **W. 1st & Main St. MO**

17. (a) **Burial** (b) Date thereof **Mar 6-47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Union Hill**

18. (a) Signature of funeral director **Ray H. Hall**

(b) Address **New 75 Col. 9 1st & Mo**

19. (a) **Mar-4-47** (b) **LeRoy Clayton**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Mar** day **4**  
year **1947** hour **1** minute **10 AM**

21. I hereby certify that I attended the deceased from **March 3**, 19**47** to **March 4**, 19**47**  
that I last saw him alive on **March 3**, 19**47**  
and that death occurred on the date and hour stated above.

Immediate cause of death **arteriosclerotic heart disease** 2-3 yr.

Due to **arteriosclerosis** - 2-3 yrs.

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

Other conditions (include pregnancy within 3 months of death)

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

Of autopsy **93D**

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 **0**

X Signature **W. Kanagawa** (M. D. or other) **MD**

Address **1 Dallmeier Bldg** Date signed **3/5/47**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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Jefferson City, Mo.

RECEIVED  
District Health Officer No. 9,  
District File Number  
Date Filed MAR 10 1947

**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 L. Ray Claypool  
Licensed Embalmer No. 4412  
P. O. Address New Bloomfield 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.