

Registration District No. **75**

Primary Registration District No. **5299**

Registrar's No. **14**

1. PLACE OF DEATH:

(a) County **CLINTON**
(b) City or town **RURAL LATHROP**
(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 **69 years** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Joseph Dudley TROTTER**
8. (b) If veteran name was
3. (c) Social Security No.

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years

7. Birth date of deceased **Sept. 20 1877**
(Month) (Day) (Year)

8. AGE: Years **69** Months **5** Days **18**
If less than one day hr. min.

9. Birthplace **CLINTON Co. Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **FARMER**

11. Industry or business **FARMING**

MOTHER FATHER
12. Name **JAMES TROTTER**
18. Birthplace **TENN.**
14. Maiden name **SUSAN WALKER**
15. Birthplace **CLINTON Co. Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **J. D. TROTTER JR.**
(b) Address **LATHROP MO.**

17. (a) **BURIAL** (b) Date thereof **3-11-47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **LATHROP MO.**

18. (a) Signature of funeral director **DEMOS CRUNK**
(b) Address **Cameroon Mo**
19. (a) **3-17-47** (b) **Mrs. Willie James**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **CLINTON**
(c) City or town **RURAL LATHROP**
(If outside city or town limits write "RURAL")
(d) Street No.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? **No.** years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **8**
year **1947** hour **unknown** M.

21. I hereby certify that I attended the deceased from **11-18**, 19**40**, to **3-7**, 19**47**
that I last saw him alive on **3-7**, 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death **haemorrhage**
Due to **ruptured Varix of esophagus**
Due to **hypertension and arteriosclerosis**
Other conditions
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations **99**
Of autopsy

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?

(Specify type of place) (e) Means of injury **2**
While at work
23. Signature **Demos Crunk** (M. D. or other) **D.O.**
Address **Lathrop Mo** Date signed **3-10-47**

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 _____

Licensed Embalmer No. _____

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, above space should be left blank.