

FILED FEB 24 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4195

BIRTH NO. _____		REG. DIST. NO. <u>47</u>		PRIMARY REG. DIST. NO. <u>3008</u>		Registrar's No. <u>31</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY <u>Callaway</u>				a. STATE <u>MO</u>		b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Fulton</u>		c. LENGTH OF STAY (In this place) <u>10 MO</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Independence</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital No 2</u>				d. STREET ADDRESS (If rural, give location) <u>114 South Spring</u>			
3. NAME OF DECEASED			4. DATE OF DEATH				
a. (First) <u>Lillie</u>			b. (Middle) <u>J</u>			c. (Last) <u>Trotyear</u>	
(Type or Print)			(Month) <u>2-</u>			(Day) <u>12-</u>	
						(Year) <u>1949</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>D. K.</u>		8. DATE OF BIRTH <u>D. K.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Ill</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13a. FATHER'S NAME <u>Irah Malcolm</u>			13b. MOTHER'S MAIDEN NAME <u>D. K.</u>			14. NAME OF HUSBAND OR WIFE <u>-----</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>N/A</u>		16. SOCIAL SECURITY NO. <u>D.K.</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Hospital records</u>			
18. CAUSE OF DEATH		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>					
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES					
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Senility</u>					
		DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS					
		Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-12-49</u> , 19____, to <u>2-12-49</u> , 19____, that I last saw the deceased alive on <u>2-11-1949</u> , 19____, and that death occurred at <u>8 A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>M. J. Miller</u>				23b. ADDRESS <u>State Hospital Fulton, Mo</u>		23c. DATE SIGNED <u>2-12-1949</u>	
24a. BURIAL (CREMATION, REMOVAL) (Specify) <u>REMOVAL</u>		24b. DATE <u>2/13/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>N/A</u>		24d. LOCATION (City, town, or county) (State) <u>INDEPENDENCE, MO</u>	
DATE REC'D BY LOCAL REG. <u>Feb 13 1949</u>		REGISTRAR'S SIGNATURE <u>Jane Mosinkoff</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Glen Y. Morgan</u> ADDRESS <u>Fulton, Mo</u>			

(Licensed Emballer's Statement on Reverse Side)

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

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RECEIVED
District Health Officer No. 9,
District File Number
Date Filed FEB 23 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed
Student Embalmer

Signed

J. J. Roston

Licensed Embalmer No. *2558*

P. O. Address *Fuller 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.