

FILED JUL 15 1949

STANDARD CERTIFICATE OF DEATH

State File No. 19249

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5468 Registrar's No. 586

1. PLACE OF DEATH
a. COUNTY Greene

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Missouri b. COUNTY Greene

b. CITY (If outside corporate limits, write RURAL and give township) Rural-Taylor Township

c. CITY (If outside corporate limits, write RURAL and give township) Rural-Taylor Township

d. FULL NAME OF HOSPITAL OR INSTITUTION Rt. 1 Strafford

d. STREET ADDRESS (If rural, give location) Rt. 1 Strafford

3. NAME OF DECEASED
a. (First) Clara b. (Middle) Saphronia c. (Last) Trogdon

4. DATE OF DEATH July 2 1949

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Jan. 15 1878

9. AGE (In years last birthday) 71 IF UNDER 1 YEAR Months 7 Days 1 IF UNDER 24 HRS. Hours 1 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Housewife

11. BIRTHPLACE (State or foreign country) Greene Co. Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Samuel Scott

13b. MOTHER'S MAIDEN NAME Mary Evans

14. NAME OF HUSBAND OR WIFE Ben Trogdon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. No

17. INFORMANT'S SIGNATURE OR NAME Ben Trogdon ADDRESS RT 1 Strafford

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia
ANTECEDENT CAUSES Broken left hip
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) _____
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH
5-6 days
2 weeks
11:30
20

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home

21c. (CITY, TOWN, OR TOWNSHIP) Springfield (COUNTY) Greene (STATE) Mo

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. _____

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? Fell on floor

22. I hereby certify that I attended the deceased from 6-25 1949 to 7-2 1949, that I last saw the deceased alive on 7-1 1949, and that death occurred at 11:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE Mrs. F. C. ... (Degree of title) M.D.

23b. ADDRESS Springfield Mo

23c. DATE SIGNED 7-5-49

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE July 6 1949

24c. NAME OF CEMETERY OR CREMATORY Danforth Cemetery

24d. LOCATION (City, town, or county) (State) 5 Mi East Spgfd Mo.

DATE REC'D BY LOCAL REG 7-7-49

REGISTRAR'S SIGNATURE W.S. Handley M.D.

25. FUNERAL DIRECTOR'S SIGNATURE J.W. Klingner & Co. ADDRESS Springfield Mo.

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

39
0
0

FEB 23 1958

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.

Student
Student Embalmer

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, fact should be so stated above.