

FILED AUG 22 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **26671**No. 300
10.48

BIRTH NO.		REG. DIST. NO. 128		PRIMARY REG. DIST. NO. 2000		Registrar's No. 737	
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) OR TOWN SPRINGFIELD		c. LENGTH OF STAY (in this place) 4 DAYS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN "RURAL" WILSON			
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOHN'S HOSPITAL				d. STREET ADDRESS (If rural, give location) BILLINGS, MO. RT. 2			
3. NAME OF DECEASED (Type or Print) SOPHIA		a. (First) SOPHIA		b. (Middle) E.		c. (Last) TROGDON	
4. DATE OF DEATH 8 17 1949		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW		8. DATE OF BIRTH 4-18-1865		9. AGE (In years last birthday) 84	
5. SEX FEMALE		6. COLOR OR RACE WHITE		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWORK	
11. BIRTHPLACE (State or foreign country) MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME MICHAEL LOVETT		13b. MOTHER'S MAIDEN NAME MELISSA OWENS	
14. NAME OF HUSBAND OR WIFE GEORGE TROGDON		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME Mr. Olen Lovett Rt. #2, Billings Mo.	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 5 minutes	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Congestive heart failure				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) (Min.)		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 June , 1949, to August 17 1949 , that I last saw the deceased alive on August 16 1949 , and that death occurred at 5:15 P.M. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Karl A. Lerdinger Jr. M.D.				23b. ADDRESS Billings, Mo.		23c. DATE SIGNED 8-18-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 8-19-1949		24c. NAME OF CEMETERY OR CREMATORY CLEAR CREEK CEM.		24d. LOCATION (City, town, or county) (State) GREENE CO. MISSOURI	
DATE REC'D BY LOCAL REG. 8-19-49		REGISTRAR'S SIGNATURE W.S. Handley M.D.		25. FUNERAL DIRECTOR'S SIGNATURE John Dean Harris		ADDRESS Cleary, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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

FEB 6 1934

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 _____

John Dean Harris

Signed _____

Student Embalmer

Licensed Embalmer No. 4390

P. O. Address Cleveland, 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.