

FILED MAR 8 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5142

BIRTH NO. _____ REG. DIST. NO. 196 PRIMARY REG. DIST. NO. 5378 Registrar's No. 76

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give town) Independence, 2		c. CITY (If outside corporate limits, write RURAL and give township) Independence Rural (Blue)	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 3537 So. Park 0480	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3537 So. Park			

3. NAME OF DECEASED (Type or Print)	a. (First) SUSIE	b. (Middle) ANNA	c. (Last) TRUAX.	4. DATE OF DEATH (Month) (Day) (Year) Feb. 25, 1950
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Mar. 20, 1888	9. AGE (In years last birthday) 61	10. UNDER 1 YEAR Months 11 Days 5	11. UNDER 12 HRS. Hours Mln.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife	10b. KIND OF BUSINESS OR INDUSTRY At home	11. BIRTHPLACE (State or foreign country) Lisbon, La.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Newton Pascal Young	13b. MOTHER'S MAIDEN NAME Mindy Hammonds	14. NAME OF HUSBAND OR WIFE Roger Dye Truax.
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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 Mrs Matt Guinn	ADDRESS 3537 So. Park.
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 24.4 hrs 331X
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) Atherosclerosis		
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"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from Feb 24, 1950, to Feb 25, 1950, that I last saw the deceased alive on Feb 24, 1950, and that death occurred at 1:08A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>Alvin L. Lewis, M.D.</i>	23b. ADDRESS 1025 N. Liberty, Indpls.	23c. DATE SIGNED 2/25/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial II	24b. DATE Feb. 27-1950	24c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery	24d. LOCATION (City, town, or county) (State) Kansas City, Mo.
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DATE REC'D BY LOCAL REG. Feb. 26-1950	REGISTRAR'S SIGNATURE <i>Alvin L. Lewis</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Debra D. Kelly</i>	ADDRESS Indep. Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

Dwight L. Kealey

Licensed Embalmer No. *4725*

P. O. Address *Indep. 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.