

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED MAR 22 1950

BIRTH NO. _____		REG. DIST. NO. <u>358</u>		PRIMARY REG. DIST. NO. <u>4523</u>		Registrar's No. <u>9</u>	
1. PLACE OF DEATH a. COUNTY <u>Vernon</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Bates</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Schell City</u>		c. LENGTH OF STAY (in this place) <u>3 mo.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rockville</u>		<u>1070</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Hillier Nursing Home</u>				d. STREET ADDRESS (If rural, give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>Bessie</u>		b. (Middle) <u>Emily</u>		c. (Last) <u>Trail</u>	
4. DATE OF DEATH		(Month) <u>March</u>		(Day) <u>17</u>		(Year) <u>1950</u>	
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>		8. DATE OF BIRTH <u>June 4-1880</u>	
9. AGE (In years last birthday) <u>69</u>		IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u>		IF UNDER 12 HRS. Hours <u>-</u> Min. <u>-</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>practical nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Chicago, Ill.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>John Williams</u>		13b. MOTHER'S MAIDEN NAME <u>Laura Ann Maloy</u>		14. NAME OF HUSBAND OR WIFE <u>Watt Trail</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. E. L. Midkiff Rockville Mo.</u>			
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) <u>Myocardial Failure</u> ANTECEDENT CAUSES <u>Thyrototoxicosis</u> Morbid 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: <u>Psychosis</u> Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u> <u>2 yrs.</u> <u>25 yr.</u> <u>1 yr.</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>none performed</u>				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>11/15</u> , 19 <u>49</u> , to <u>3/17</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>3/14</u> , 19 <u>50</u> , and that death occurred at <u>3 p. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>M. O. Bjork</u>				23b. ADDRESS <u>Rockville, Mo.</u>		23c. DATE SIGNED <u>3/18/50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Mar. 6/1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Rockville, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>Mar 18-1950</u>		REGISTRAR'S SIGNATURE <u>Mrs Sarah E. King</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Lewis &amp; Son</u>		ADDRESS <u>Schell City, Mo.</u>	

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

080  
4

RECEIVED

District Health Officer No. 7,

District File Number 2-50-257

Date Filed 3-21-20

---

---

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 Marion M. Lewis

Licensed Embalmer No. 3084

P. O. Address Schell City, 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.