

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED FEB 1 1953

BIRTH NO. _____ REG. DIST. NO. 324 PRIMARY REG. DIST. NO. 3072 Registrar's No. 25

1. PLACE OF DEATH a. COUNTY Saline		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Saline	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Marshall		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Marshall	
c. LENGTH OF STAY (in this place) 1 Hour		d. STREET ADDRESS (If rural, give location) 321 N. Sargent	
d. FULL NAME OF HOSPITAL OR INSTITUTION Witzgibbon Hospital.			

3. NAME OF DECEASED (Type or Print) Hattie Triggs			4. DATE (Month) (Day) (Year) OF DEATH Jan 27, 1953		
a. (First)	b. (Middle)		c. (Last)		
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Sept. 2, 1907	9. AGE (In years last birthday) 45	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House keeping		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Missouri (Saline County)	
				12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Clem Carrol	13b. MOTHER'S MAIDEN NAME Cora Steward	14. NAME OF HUSBAND OR WIFE Deceased
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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. none	17. INFORMANT'S SIGNATURE OR NAME Mrs. Kathryn Robinson, K.C. Mo.	ADDRESS
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lobar pneumonia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hepatitis DUE TO (c) Anemia II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 490X		INTERVAL BETWEEN ONSET AND DEATH 4 days
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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)	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 investigated, on Jan 27, 1953, that I last saw the deceased alive on Jan 27, 1953, and that death occurred at 12:00 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dr. Lawrence Coroner Saline Co. 3 Marshall	23b. ADDRESS	23c. DATE SIGNED 1-28-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1/31/53	24c. NAME OF CEMETERY OR CREMATORY Nelson	24d. LOCATION (City, town, or county) (State) Nelson, Mo. Saline County
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DATE REC'D BY LOCAL REG. 1-30-1953	REGISTRAR'S SIGNATURE Sidney J. Gray	385	25. FUNERAL DIRECTOR'S SIGNATURE Benjamin L. Green	ADDRESS Marshall, 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

George H. Green

Licensed Embalmer No. 4220

P. O. Address Marshall, 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.