

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

14671

FILED APR 24 1953

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 146 PRIMARY REG. DIST. NO. 5568 Registrar's No. 165

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)	
a. COUNTY <u>JACKSON (Rural Blue)</u>	b. CITY (If outside corporate limits, write RURAL and give township) <u>Independence</u>	a. STATE <u>Missouri</u>	b. COUNTY <u>JACKSON</u>
c. LENGTH OF STAY (in this place) <u>2 yrs.</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>Independence</u>	OR TOWN <u>7005</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Miss Rest Home</u>	d. STREET ADDRESS (If rural, give location) <u>725 So. Main</u>		

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Evv</u>	b. (Middle) <u>DELL</u>	c. (Last) <u>TRUFF</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>April 17 1953</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed - 7</u>	8. DATE OF BIRTH <u>October 29 1880</u>	9. AGE (In years, last birthday) <u>72</u>	10. UNDER 1 YEAR Months <u>5</u> Days <u>18</u>	11. UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Three Rivers, Michigan</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Charles L. Young</u>	13b. MOTHER'S MAIDEN NAME <u>Folly Youngs</u>	14. NAME OF HUSBAND OR WIFE <u>J. W. Trufa</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Ruth M. Towerson</u>	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		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>unknown</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arterio sclerosis</u> DUE TO (c)		
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 <u>331x</u>	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 8-12 1952 to 17 April, 1953 that I last saw the deceased alive on 14 April, 1953 and that death occurred at 3 P.m., from the causes and on the date stated above.

23a. SIGNATURE <u>J. Saunders MD</u> (Degree or title)	23b. ADDRESS <u>Independence</u>	23c. DATE SIGNED <u>4-18-53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <u>Apr 19 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Oakwood Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Joliet Illinois</u>
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DATE REC'D BY LOCAL REG. <u>4-19-53</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u> <u>354</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>	ADDRESS <u>Independence</u>
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WRITE PLAINLY—USING INK—FILLING IN SPACES

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

Wilton L. Kephly

Licensed Embalmer No. 4225

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.