

FILED OCT 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36063

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8617**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Howell	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. CITY OR TOWN Willow Springs	
c. LENGTH OF STAY (in this place)		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		No. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print)	a. (First) LINDELL	b. (Middle) WILLARD	c. (Last) TRUMP	4. DATE OF DEATH (Month) (Day) (Year) Sept. 19 1954
-------------------------------------	---------------------------	----------------------------	------------------------	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 25, 1911	9. AGE (In years last birthday) 42	IF UNDER 1 YEAR (Month) (Day) (Year) 1954	IF UNDER 2 HRS. (Hour) (Min.)
--------------------	-------------------------------	---	---------------------------------------	---	--	-------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deliveryman	10b. KIND OF BUSINESS OR INDUSTRY Furniture	11. BIRTHPLACE (City and State or Foreign Country) East Prairie, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	--	---	--

13a. FATHER'S NAME Gus Trump	13b. MOTHER'S MAIDEN NAME Minnie Tucker	14. NAME OF HUSBAND OR WIFE Dorothy Trump
-------------------------------------	--	--

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. Dorothy Trump, Willow Springs, Mo	ADDRESS
--	-------------------------------------	---	---------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Edema		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive Cardiovascular Heart Disease DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Glomerulonephritis			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 443X
---	--	--

22. I hereby certify that I attended the deceased from **9-3**, 19 **54**, to **9-19**, 19 **54**, that I last saw the deceased alive on **9-19**, 19 **54**, and that death occurred at **7** **00** p. m., from the causes and on the date stated above.

23a. SIGNATURE <i>C. S. ... M.D.</i>	23b. ADDRESS BARNES HOSPITAL	23c. DATE SIGNED 9-20-54
--------------------------------------	-------------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 9-21-54	24c. NAME OF CEMETERY OR CREMATORY Willow Springs Cemetery	24d. LOCATION (City, town, or county) (State) Willow Springs, Mo.
--	--------------------------	---	--

DATE REC'D BY LOCAL REG. SEP 21 1954	REGISTRAR'S SIGNATURE <i>Albert H. Hoppe</i>	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington.
---	--	---	---------------------------------

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

OCT 26

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.....
Signature of Student Embalmer

Signed John S. Denne
Licensed Embalmer No. 419
P. O. Address St. Louis

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.