

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37545**

FILED NOV 21 1955

BIRTH NO. _____ REG. DIST. NO. **224** PRIMARY REG. DIST. NO. **3046** Registrar's No. **86**

1. PLACE OF DEATH a. COUNTY Monterey		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Massachusetts b. COUNTY Monterey	
b. CITY (If outside corporate limits, write RURAL, and give township) OR TOWN California		c. LENGTH OF STAY (in this place) 19 days	c. CITY OR TOWN California
d. FULL NAME OF HOSPITAL OR INSTITUTION Latham Sanatorium		f. STREET ADDRESS (If rural, give location) 268/2	

3. NAME OF DECEASED (Type or Print)	a. (First) EMMA	b. (Middle)	c. (Last) TRIEBER	4. DATE OF DEATH	(Month) Nov.	(Day) 16	(Year) 1955
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5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Dec 6, 1862	9. AGE (In years last birthday) 92	IF UNDER 1 YEAR Months 11 Days 10	IF 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) housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) California, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Frank Hotrecht	13b. MOTHER'S MAIDEN NAME Elizabeth Schaffe	14. NAME OF HUSBAND OR WIFE Chas. C. Trieter
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Elie Wilson	ADDRESS California, Mo.
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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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis		1 year
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis DUE TO (c) 4221F		10 year
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Fracture of hip			1 month

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)
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?

22. I hereby certify that I attended the deceased from **Oct 15, 1955**, to **Nov 16, 1955**, that I last saw the deceased alive on **Nov. 16, 1955**, and that death occurred at **10P m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Kennyon Latham M.D.	23b. ADDRESS California, Mo.	23c. DATE SIGNED 11-18-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE Nov. 19, 1955	24c. NAME OF CEMETERY OR CREMATORY Masonic	24d. LOCATION (City, town, or county) (State) California Mo.
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DATE REC'D BY LOCAL REG. Nov 20-55	REGISTRAR'S SIGNATURE H. K. Pope	25. FUNERAL DIRECTOR'S SIGNATURE A. E. Wilson	ADDRESS California Mo
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WRITE PLAINLY—USING UNFADEING 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.....
Signature of Student Embalmer

Signed..... *A. E. Wilson*

Licensed Embalmer No. *235*

P. O. Address *California*

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.