

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED MAY 10 1956

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 150 PRIMARY REG. DIST. NO. 4241 Registrar's No. 72

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Oak Grove</u>		c. CITY OR TOWN <u>Oak Grove</u>	
c. LENGTH OF STAY (in this place) <u>50 yrs</u>		d. Is residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>City</u>		STREET ADDRESS (If rural, give location) <u>City</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Addie</u> b. (Middle) <u>M</u> c. (Last) <u>Trigg</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>April 19-1956</u>		
5. SEX <u>F</u>		6. COLOR OR RACE <u>wh</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	
8. DATE OF BIRTH <u>May-29-1879</u>		9. AGE (In years last birthday) <u>76</u>		IF UNDER 1 YEAR: Months _____ Days _____	
IF UNDER 24 HRS. Hours _____ Mins. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Wifes</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (City and State or Foreign Country) <u>Oak Grove Mo</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		

13a. FATHER'S NAME <u>Ruben Mabry</u>		13b. MOTHER'S MAIDEN NAME <u>Dora Moore</u>		14. NAME OF HUSBAND OR WIFE <u>Dan F. Trigg</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>D.F. Trigg</u> ADDRESS <u>Oak Grove 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>Cerebral Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 mo</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, general</u>		DUE TO (c) _____	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>Arterio Sclerosis Heart Disease 1 yr</u>			

19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		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) _____		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 ~~1950~~ 1950, 1950 to 4-19, 1956, that I last saw the deceased alive on 4-19, 1956, and that death occurred at 6:20 pm., from the causes and on the date stated above.

23. SIGNATURE (Degree or title) <u>J. Alice C. Brown MD</u>		23b. ADDRESS <u>Oak Grove Mo</u>		23c. DATE SIGNED <u>4-19-56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		24b. DATE <u>4-21-1956</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u>	
24d. LOCATION (City, town, or county) (State) <u>Oak Grove Mo</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Webb Funeral Home</u>		ADDRESS <u>Oak Grove Mo</u>	

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

MISSOURI 1927

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 *R. B. Webb* .....

Licensed Embalmer No. *2353* .....

P. O. Address *Blue Springs* .....

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.