

FEDERAL BUREAU OF INVESTIGATION - DEPARTMENT OF JUSTICE
FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

REGISTRATION DISTRICT NO. 210 PRIMARY REGISTRATION DISTRICT NO. 422 REGISTRAR'S NO. 70 STATE FILE NUMBER 60-035518

1. PLACE OF DEATH a. COUNTY <u>MERCER</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>MERCER</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>PRINCETON</u>		Length of stay in 1b		c. CITY OR TOWN <u>MODENA</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>LAMBERT HOSPITAL</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>TRAINER</u> Last <u>TRAINER</u>				4. DATE OF DEATH Month <u>SEPT</u> Day <u>29</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>10-3-1878</u>	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>MERCER CO. MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>HOWARD ETHEBERTON</u>			13b. MOTHER'S MAIDEN NAME <u>ELIZABETH GRAHAM</u>		14. NAME OF HUSBAND OR WIFE <u>EDGAR TRAINER</u>		
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.		17. INFORMANT Address <u>GENE TRAINER MODENA MO</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PASSIVE CONGESTIVE HEART FAILURE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) <u>GENERALIZED ARTERIOSCLEROSIS</u>	
						DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>BRONCHIECTASIS, CHRONIC CHOLECYSTITIS + CHOLELITHIASIS.</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 15.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year						
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>August 1960</u> to <u>Sept. 29, 1960</u> and last saw her alive on <u>Sept. 29, 1960</u> Death occurred at <u>2:10 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree, or title) <u>Oran H. Gilbert MD</u>				22b. ADDRESS <u>210 W. Main, Princeton, MO</u>		22c. DATE SIGNED <u>9-30-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>OCT-2-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BRUMMETT CEMETERY</u>		23d. LOCATION (City, town, or county) <u>MERCER CO. MO.</u>		(State)	
24. FUNERAL DIRECTOR <u>SCHOOLER FUNERAL HOME SPICKARD MO</u>		ADDRESS		25. DATE RECD. BY LOCAL REG. <u>9-30-60</u>	26. REGISTRAR'S SIGNATURE <u>Heel Moss</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 *Ross Wise*

Licensed Embalmer No. 3771

P. O. Address *Spickard M*

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.