

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-51-017835

STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2206

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		c. CITY OR TOWN <b>Kansas City</b>	
Length of stay in 1b <b>67 Years</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lakeside Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>4214 Roanoke Road</b>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>E.</b> Last <b>TROGDON</b>			4. DATE OF DEATH Month <b>May</b> Day <b>3</b> Year <b>1961</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4-28-1874</b>
9. AGE (last birthday) <b>87</b>		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) <b>Attorney (Retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Law Practice</b>	11. BIRTHPLACE (City and state or country) <b>Paris, Illinois</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13a. FATHER'S NAME <b>Isaac Trogdon</b>		13b. MOTHER'S MAIDEN NAME <b>Sally Cox</b>	
14. NAME OF HUSBAND OR WIFE <b>Dora Trogdon</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <b>Mrs. Dora Trogdon, Kansas City, Mo.</b>		Address <b>4214 Roanoke Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Embolus</b>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Mesenteric Atherosclerosis</b>			
DUE TO (c) <b>Carcinoma of Sigmoid Colon</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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 18.)	
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 <b>3/25/61</b> to <b>5/3/61</b> and last saw her him alive on <b>5/3/61</b> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>W. Morley D.O.</b>		22b. ADDRESS <b>336 West 36th St. Kansas City, Mo.</b>	
22c. DATE SIGNED <b>5/3/61</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>May 5, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Moriah Cemetery</b>	
23d. LOCATION (City, town, or county) <b>Kansas City, Mo.</b>			
24. FUNERAL DIRECTOR <b>Freeman Mortuary</b>	ADDRESS <b>Kansas City, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>5-4-61</b>	26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

W.C. WORLEY

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 Clayton A. Barne

Licensed Embalmer No. 4793

P. O. Address F. C. 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.