

Registration District No. 251

Primary Registration District No. 4151

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Daviess 2  
(b) City or town Jameson  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
-----  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 47 Years  
years, months or days

3. (a) PRINT 6515  
FULL NAME Albert Buren Trotter

3. (b) If veteran, name war. ----- 3. (c) Social Security No. -----

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Mary H. Trotter  
6. (c) Age of husband or wife if alive 78 years  
7. Birth date of deceased March 21 1857  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>82</u>	<u>9</u>	<u>5</u>	hr. _____ min.

9. Birthplace Middlefork Indiana  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Retired 1924

12. Name Wm. S. Trotter  
13. Birthplace Unknown Ohio  
(City, town, or county) (State or foreign country)  
14. Maiden name Emily Pittsenbarger  
15. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mary A Trotter  
(b) Address Jameson, Mo.  
17. (a) Burial (b) Date thereof 12-28-39  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Scotland Cemetery

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address Gallatin, Mo.  
19. (a) Dec 28, 1939 (b) Ira Pugh  
(Date received local registry) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Daviess  
(c) City or town Jameson  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 26  
year 1939 hour 4 minute 00 A. M.

21. I hereby certify that I attended the deceased from 6-18-39, 19\_\_\_\_, to 12-25-39, 19\_\_\_\_;  
that I last saw him alive on 12-25-39, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Pneumonia</u>	<u>7 day</u>
<u>Broken branch heart</u>	<u>456</u>
Other conditions: <u>3-partial paralydgia</u> <u>Sarcoid</u>	
Of autopsy <u>No</u>	

PHYSICIAN  
Underline initials to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
(d) Did injury occur near about home, on farm, in industrial place, in public place?  
While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (Means of injury)  
28. Signature Edward O. Nelson MD M. D. or Other \_\_\_\_\_  
Address Gallatin, Mo Date signed 12/27/39

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Health Officer No. 11

District File Number

140-1848

Date Filed

JAN 10 1940

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed

*L.A. Richesson*

Licensed Embalmer No.

3302

P. O. Address

*Gallatin, T*

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 this body is not embalmed, above space should be left blank.