

S. No. 2
-11-10-39
-5-17-39
-I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 34544
Registrar's No. 4060

Registration District No. 1900

Primary Registration District No. 1000

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Luke's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: in hospital or institution 12 Days
(Specify whether years, months or days) In this community 37 Years

3. (a) PRINT FULL NAME Mrs. Della C. Trowbridge
8. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female race White 5. Color or divorced Married
6. (b) Name of husband or wife Mr. Carl Y. Trowbridge 6. (c) Age of husband or wife if alive 68 years
7. Birth date of deceased January 31 1877
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
63 8 21 hr. min.

9. Birthplace Mansfield Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business --

MOTHER FATHER { 12. Name J. W. Baker
13. Birthplace Wright County Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Nancy Walters
15. Birthplace Wright County Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Carl Trowbridge
(b) Address 4016 Chestnut

17. (a) Burial (b) Date thereof Oct. 23 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director O. B. Jewell's Sons
(b) Address 1401 Brush Creek Blvd.

19. (a) 10-22-40 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 4016 Chestnut Avenue
(If rural, give location)
(e) If foreign born, how long in U. S. A.? -- years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month October day 21st
year 1940 hour 6 minute 59 A. M.

21. I hereby certify that I attended the deceased from 19 to 10/21/40, 1940
that I last saw her alive on 10/20/40, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Peritonitis & Intestinal Obstruction Duration 12 da

Due to Carcinoma of Colon & Diverticulosis ? 10 yrs

Due to _____
Other conditions 46
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy Diverticulosis of Small Intestine & Carcinoma of Colon
Underline the cause to which death should be charged Intestine

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 in or about home, on farm, in industrial place, in public place? _____

23. Signature [Signature] (M. D. or other) M.D.
Address 311 1/2 Maple Date signed 10/21/40
Specify type of place (e) Means of injury _____

Angela Blay

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 *H.C. Newcomer Jr*

Licensed Embalmer No. *4045*

P. O. Address *H.C. No.*

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.