

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.

**MISSOURI STATE BOARD OF HEALTH**  
**BUREAU OF VITAL STATISTICS**  
**CERTIFICATE OF DEATH**

**34928**  
 Do not use this space.

1. PLACE OF DEATH 20

(a) County CALDWELL Registration District No. 94

(b) Township \_\_\_\_\_ Primary Registration District No. 4056 Registered No. \_\_\_\_\_

(c) City BRECKENRIDGE (d) Street No. \_\_\_\_\_ (If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_

(e) Length of residence in city or town where death occurred life mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME MINA GRANT TROSPER

(a) Residence, No. Breckenridge mo St.  (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX FEMALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF WILLIAM TROSPER

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 30 1868

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	72	1	17	

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House Wife

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Livingston CO mo.

FATHER 13. NAME William A. Tuller

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ind.

MOTHER 15. MAIDEN NAME Sarah Blackman

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Grundy CO mo.

17. INFORMANT M. S. Trospen (ADDRESS) Breckenridge mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Rose Hill DATE Oct. 19 1940

19. FUNERAL DIRECTOR (NAME) T. McPeck (ADDRESS) Breckenridge mo

20. FILED Oct 19 1940 A. P. Hilkey M. D. Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 17 1940

22. I HEREBY CERTIFY, That I attended deceased from Oct 7 1940 to Oct 17 1940

I last saw her alive on Oct 17 1940 Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Edema Lingae (Bilateral) Date of onset 10/15/40  
Chronic Bronchonia Rt 10/14/40  
following Influenza 10/12/40

Other contributory causes of importance: Mitral Insufficiency Chronic Nephritis Arterio Sclerotic Kidney

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify \_\_\_\_\_ (Signed) E. L. Woolsey M. D.  
 (Address) Braymer mo

**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 T. J. McBeek

Licensed Embalmer No. 1570

P. O. Address Brockton, Mass.

**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.