

FILED FEB 18 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **1184**
Registrar's No. **144**

Registration District No. **299** Primary Registration District No. **1002**

1. PLACE OF DEATH:
(a) County **Jackson**
(b) City or town **Kansas City Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Little Sisters of the Poor 3**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. **2 Months 27 Days**
41 Yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson** **48**
(c) City or town **Kansas City Mo.** **8**
(If outside city or town limits, write "RURAL")
(d) Street No. **3309 Gillam Plaza.**
(If rural, give location) **0**
(e) If foreign born, how long in U. S. A. _____ years.

8. (a) PRINT FULL NAME **Peter J. TRUDELL.**
3. (b) If veteran, name war. **No** 3. (c) Social Security No. **No**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **January** day **9th**
year **1941** hour **4:05** minute **6** P. M.

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced. **2 Widowed**
6. (b) Name of husband or wife **Mary M. Trudell** 6. (c) Age of husband or wife if alive _____ years

21. I hereby certify that I attended the deceased from **Deaths** 19 **40** to **Jan 9** 19 **41**
that I last saw h. **in** alive on **Jan 6** 19 **41**
and that death occurred on the date and hour stated above.
Immediate cause of death **Cerebral hemorrhage** **Diphtheria**

7. Birth date of deceased **July 22nd, 1860**
(Month) (Day) (Year)

Due to **arteriosclerosis**
hypertension **years**

8. AGE: Years **80** Months **5** Days **17** If less than one day hr. _____ min. _____

Due to _____
Other conditions (Include pregnancy within 3 months of death) **830**

9. Birthplace **Missouri** (City, town, or county) (State or foreign country)
10. Usual occupation **Retired**
11. Industry or business **Laborer Water Dept.**
12. Name **Samuel Trudell.**
13. Birthplace **Canada** (State or foreign country)
14. Maiden name **Delia Ledue**
15. Birthplace **Missouri** (City, town, or county) (State or foreign country)

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant **Sister Camille**
(b) Address **5331 Highland Ave. K.C. Mo.**
17. (a) **Burial** (b) Date thereof **1/10/41**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **St. Marys**
18. (a) Signature of funeral director **Melody-McGilley**
(b) Address **K. C. Mo.**
19. (a) **Jan 11, 1941** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

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? _____
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature **John T. Shuman** (M. D. or other) **MD**
Address **146 2 B Grant Bldg** Date signed **1-10-41**
K. G. M. B.

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

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 267
_____, Registered Apprentice No. _____
working under my personal supervision.

Signed J. B. Ryan
Licensed Embalmer No. 2999
P. O. Address KC

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.