

FILED DEC 11 1943

Registration District No. **310**

Primary Registration District No. **3058**

1. PLACE OF DEATH:

(a) County **St Charles**  
(b) City or town **St Charles**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**at home 1501 - on Smith**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St Charles**  
(c) City or town **St Charles**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **1501 N. 4th St**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Georgia Trout**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. **none**

4. Sex **Female** 5. Color or race **Black** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Louis Trout** 6. (c) Age of husband or wife if alive **approx 45** years

7. Birth date of deceased **June 8 1903**  
(Month) (Day) (Year)

8. AGE: Years **40** Months **5** Days **2** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **Warren County Mo**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housework**

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
{ 12. Name **George Smith**  
13. Birthplace **Uniontown Mo**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Annie Stewart**  
15. Birthplace **Warren County Mo**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Leslie Luckett**

(b) Address **1428 N Smith, St Charles, Mo**

17. (a) **Burial** (b) Date thereof **Nov 26-1943**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Wright City Mo**

18. (a) Signature of funeral director **H. C. Dallmeyer**

(b) Address **800 N 2nd St Charles Mo**

19. (a) **11/22/1943** (b) **Conrad C. Paul**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **21**  
year **1943** hour **2** minute **30** A.M.

21. I hereby certify that I attended the deceased from **Nov 5** 1943 to **Nov 20** 1943

that I last saw **her** alive on **Nov 20** 1943

and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Nephritis Uremia with dyspnea**

Due to **Nephritis**

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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) (c) Manner of injury \_\_\_\_\_

23. Signature **Dr. N. H. Taylor** (M. D. or other) \_\_\_\_\_

Address **200 N Main** Date signed **11-27-43**

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

13 1/2

**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: *John E. Dellmeyer*  
Licensed Embalmer No. *2951*  
P. O. Address *St Charles Mo*

**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, fact should be so stated above.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 12ec

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County St. Charles

(b) City or town St. Charles  
(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 \_\_\_\_\_  
(years, months or days)

3. (a) PRINT FULL NAME Georgia Trout

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

4. Sex 7 5. Color or race B 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased June 2  
(Month) (Day) (Year)

8. AGE: Years 40 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Charles

(c) City or town St. Charles  
(If outside city or town limits, write "RURAL")

(d) Street No. 1501 N. High St.  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov Day 26 year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death acute nephritis  
uremia & dropsy

Due to nephritis

Due to acute nephritis (chronic history, nothing would indicate chronic nephritis) entered only under my observation 15 days.

(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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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) \_\_\_\_\_  
(a) Means of injury \_\_\_\_\_

23. Signature Dr. W. H. C. [unclear] (M. D. or other) \_\_\_\_\_  
Address 200<sup>th</sup> N. Main St. St. Charles, Mo. Date signed 1/14/43

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

SUPPLEMENTARY

MOTHER FATHER

PHYSICIAN  
Underline the cause to which death should be charged statistically.

S-39010