

Registration District No. **107**

Primary Registration District No. **3032**

Registrar's No. **103**

1. PLACE OF DEATH:

(a) County Johnson

(b) City or town Warrensburg
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Warrensburg Clinic
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 20 Hrs
(Specify whether years, months or days)

In this community 20 Hrs
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Johnson

(c) City or town Warrensburg
(If outside city or town limits, write "RURAL")

(d) Street No. Warrensburg Clinic
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Lary Mac Trout

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct 20 1945
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

0 0 0 20 hr. 0 min.

9. Birthplace Warrensburg Mo
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER { 12. Name Cecil Mack Trout

13. Birthplace Casselman Penn
(City, town, or county) (State or foreign country)

14. Maiden name Pauline Phillips

15. Birthplace Summerset Co. Penn
(City, town, or county) (State or foreign country)

16. (a) Informant Cecil Mac Trout

(b) Address _____

17. (a) Burial (b) Date thereof Oct. 22-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Hill

18. (a) Signature of funeral director Sweeney Phillips

(b) Address Warrensburg Mo.

19. (a) Oct. 22-45 (b) Sarah Ann Cretchfield
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 21
year 1945 hour 2:17 minute 30 A: M.

21. I hereby certify that I attended the deceased from Oct. 20
1945 to Oct 21 1945

that I last saw him alive on Oct 21 1945
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Cerebral injury with respiratory failure 21 hrs

Due to birth injury 21 hrs

Due to systemic _____

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

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause 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 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 [Signature] (M. D. or other) M.D.

Address Warrensburg Mo. Date signed 10-22-45

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

51
2
2

1686

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.....

Licensed Embalmer No. 3878

P. O. Address. Warrensburg 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.