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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED JAN 27 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

665

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. 4168

Registrar's No. 80

1. PLACE OF DEATH:

(a) County DEKALB

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

(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 25 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County DEKALB

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

(d) Street No. \_\_\_\_\_ (If rural, give location)

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

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME ANNA BELLE TROTTER

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month JAN day 5  
year 1947 hour 1 minute 35 P. M.

4. Sex F 5. Color or race W

6. (a) Single ~~married~~, divorced M

6. (b) Name of husband or wife HENRY TROTTER

6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased JULY-25-1874  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec 27, 1946 to Jan 5, 1947  
that I last saw her alive on Jan 5, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis 9 days  
Duration \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
72 5 10 hr. min.

Due to Hypertension

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

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

10. Usual occupation HOUSEWIFE

Other conditions arterio-sclerosis  
(Include pregnancy within 3 months of death)

MOTHER FATHER

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

12. Name WARREN FITE

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

14. Maiden name HANNAH YOKES

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

Major findings: Of operations gyp

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

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

16. (a) Informant Henry Trotter

(b) Address Marshall MO

17. (a) Burial (b) Date thereof 1/7-47  
(Burial, cremation, or disposal) (Month) (Day) (Year)

(c) Place: Oak Lawn Mausoleum

18. (a) Signature of funeral director FRANK FINE

(b) Address MAYSVILLE MO

19. (a) 1/7-47 (b) Robert Davidson  
(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 2

23. Signature R. R. Reynolds (M. D. or other) MD

Address Marshall MO Date signed 7-47

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

**DISTRICT HEALTH OFFICE**  
**Cameron, Mo.**

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**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. *3960*

P. O. Address *Marysville 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.**