

FILED APR 27 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

13095

State File No. ....

 BIRTH NO. 134 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 6045 Registrar's No. 114

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>St. Francois</u>   |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Raynolds</u> |  |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR <u>Farmington</u><br>TOWN <u>Rural St. Francois</u> |  | c. LENGTH OF STAY (in this place)<br><u>3 Mos. 3 das.</u> | c. CITY (If outside corporate limits, write RURAL and give township)<br>OR <u>Black</u><br>TOWN <u>Black River Twp</u>                      |  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri State Hospital No. 4</u>   |  |   | d. STREET ADDRESS (If rural, give location)<br><u>10 miles west of Black</u>  |  |  |

|  |                           |                             |   |  |  |
|--|---------------------------|-----------------------------|---|--|--|
| 3. NAME OF DECEASED<br>(Type or Print) |                           |                             | 4. DATE OF DEATH                              |  |  |
| a. (First) <u>THOMAS</u>               | b. (Middle) <u>MONROE</u> | c. (Last) <u>TROLLINGER</u> | (Month) (Day) (Year)<br><u>April 14, 1954</u> |  |  |

|                       |                                  |  |   |                                 |                                    |                            |
|-----------------------|----------------------------------|--|---|---------------------------------|------------------------------------|----------------------------|
| 5. SEX<br><u>Male</u> | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><u>Married</u> | 8. DATE OF BIRTH<br><u>Dec. 3, 1889</u> | 9. AGE (In years last birthday) | 10. IF UNDER 1 YEAR                | 11. IF UNDER 24 HRS.       |
|                       |                                  |  |   | <u>64</u>                       | <u>4</u>   <u>11</u>   <u>Days</u> | <u>Hours</u>   <u>Min.</u> |

|   |                                   |  |   |
|---|-----------------------------------|--|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Farming</u> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and State or Foreign Country)<br><u>Black, Missouri</u> | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u> |
|---|-----------------------------------|--|---|

|  |  |   |
|--|--|---|
| 13a. FATHER'S NAME<br><u>John Henry Trollinger</u> | 13b. MOTHER'S MAIDEN NAME<br><u>Matilda Anderson</u> | 14. NAME OF HUSBAND OR WIFE<br><u>Vienna Barton -2nd wife</u> |
|--|--|---|

|   |  |  |         |
|---|--|--|---------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u> | 16. SOCIAL SECURITY NO.<br><u>None</u> | 17. INFORMANT'S SIGNATURE OR NAME<br><u>Records, State Hospital No. 4, Farmington, Mo.</u> | ADDRESS |
|---|--|--|---------|

|   |  |  |                                  |
|---|--|--|----------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION  |  | INTERVAL BETWEEN ONSET AND DEATH |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Uremia</u>   |  | <u>abt. 24 hrs.</u>              |
|   | ANTECEDENT CAUSES<br>*Forbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Nephrosclerosis</u><br>DUE TO (c) <u>Hypertensive cardiovascular renal disease</u> |  | <u>Unknown</u>                   |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |  | <u>Psychosis with cerebral arteriosclerosis.</u> |                                  |

|                        |   |   |
|------------------------|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION<br><u>442X</u> | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------|---|---|

|  |  |   |
|--|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
|--|--|---|

|   |  |                            |
|---|--|----------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
|---|--|----------------------------|

22. I hereby certify that I attended the deceased from January 17, 54 to April 14, 1954, that I last saw the deceased alive on April 14, 1954, and that death occurred at 8:10A.m., from the causes and on the date stated above.

|  |  |                                    |
|--|--|------------------------------------|
| 23a. SIGNATURE (Degree or title)<br><u>John A. Brennan, M.D.</u> | 23b. ADDRESS<br><u>State Hospital No. 4, Farmington, Mo.</u> | 23c. DATE SIGNED<br><u>4-16-54</u> |
|--|--|------------------------------------|

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u> | 24b. DATE<br><u>April 16, 54</u> | 24c. NAME OF CEMETERY OR CREMATORY<br><u>Volner Cemetery</u> | 24d. LOCATION (City, town, or county) (State)<br><u>Black, Missouri</u> |
|--|----------------------------------|--|---|

|  |  |  |         |
|--|--|--|---------|
| DATE REC'D BY LOCAL REG.<br><u>Apr. 16, 1954</u> | REGISTRAR'S SIGNATURE<br><u>Ethel R. ...</u> | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>White Funeral Home, Ironton, Missouri</u> | ADDRESS |
|--|--|--|---------|

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed \_\_\_\_\_

*Lyle P. White*

Licensed Embalmer No. 4295

P. O. Address Winton, Pa.

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.