

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **44083**
Registrar's No. **11705**

FILED JAN 18 1955

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE 770 b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL, and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2179	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis State Hosp.		d. STREET ADDRESS (If rural, give location) 4444 Castlerman	
3. NAME OF DECEASED (Type or Print) a. (First) Martha b. (Middle) Adeline c. (Last) Trimble			4. DATE OF DEATH (Month) (Day) (Year) 12-23-1954
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) DIVORCED	8. DATE OF BIRTH May 15-1900
9. AGE (In years last birthday) 54		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical Wk.	10b. KIND OF BUSINESS OR INDUSTRY Retail Store
11. BIRTHPLACE (City and State or Foreign Country) Hillsboro, 770		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME John J. Trimble		13b. MOTHER'S MAIDEN NAME Mary Wilson	14. NAME OF HUSBAND OR WIFE None
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Bertha Trimble - St. Louis
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral vascular accident ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Adenocarcinoma of sigmoid DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 153x
22. I hereby certify that I attended the deceased from 3-31 , 1954 , to 12-23 , 1954 that I last saw the deceased alive on 12-22 , 1954 and that death occurred at 7:05A m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Anna Hyman MD		23b. ADDRESS 5400 Arsenal St	23c. DATE SIGNED 12-23-54
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 12-26-54	24c. NAME OF CEMETERY OR CREMATORY Bethlehem	24d. LOCATION (City, town, or county) (State) Grubville 770
DATE REC'D BY LOCAL REG. DEC 24 1954		REGISTRAR'S SIGNATURE J. Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Lee Mothershead Do Sob, MO

(Licensed Embalmer's Statement on Reverse Side)

JAN 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Andrew H England

Licensed Embalmer No. 4745-

P. O. Address De Soto, 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.