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9876

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registrar's No. _____

DEC 13 1939 791

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(c) Name of hospital or institution: City Hosp #1
(d) Length of stay: In hospital or institution 12 Days
In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
(c) City or town St. Louis
(d) Street No. 3640a Easton Ave
(e) If foreign born, how long in U. S. A. _____

3. (a) PRINT FULL NAME

Addie Trappe

(b) If veteran, name war _____

Nil

(c) Social Security No. Nil

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Fredrick

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

7. Birth date of deceased Aug 19th, 1874

8. AGE:

Years 65

Months 2

Days 29

If less than one day hr. _____ min. _____

9. Birthplace

(City, town, or county) _____

Illinois

(State or foreign country)

10. Usual occupation

At Home

11. Industry or business

MOTHER FATHER

12. Name Ambrose Bequette

13. Birthplace Unknown

14. Maiden name Mary Louise Leviere

15. Birthplace Unknown

16. (a) Informant's own signature Fredrick Trappe

(b) Address 4724a San Francisco

17. (a) Burial (b) Date thereof 11/21/39

(c) Place: burial or cremation Calvary Cemt

18. (a) Signature of funeral home Herrigan & Sheahan Und Co

(b) Address 4415 Washington Blvd.

19. NOV 20 1939 (Date received local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 18 day Nov
year 1939 hour 11:45am minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of left tibia; Aterio Sclerofis
suffered when she slipped
Due to + fell to floor at her home
3640 Easton Avenue November
5th 1939 about 2:30 A.M.

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? _____
(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 Joseph [Signature] (M. D. or other) _____
Address Deputy [Signature]

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....

Homer W. Fritz

Licensed Embalmer No.....

38820

P. O. Address.....

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, above space should be left blank.