

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.

JAN 12 1940 701  
Registration District No. **1000**

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

1. PLACE OF DEATH: **2**

(a) County \_\_\_\_\_  
(b) City or town **St. Louis**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**1111 Forest**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **None**  
(Specify whether \_\_\_\_\_)  
In this community **Unknown**  
years, months or days

2. USUAL RESIDENCE OF DECEASED: **1**

(a) State **Missouri** (b) County \_\_\_\_\_  
(c) City or town **St. Louis** **4**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **1111 Forest**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? **82 Years** years.

3. (a) PRINT FULL NAME **Katharina Trau** **602**  
3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **2nd**  
year **1939** hour **4:45 PM** minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from **1930**  
\_\_\_\_\_, 19\_\_\_\_, to **DEC. 2, 1939**, 19\_\_\_\_;  
that I last saw h ER alive on **DEC. 2, 1939**  
and that death occurred on the date and hour stated above.

4. Sex **Female** 5. Color or race **White**  
6. (a) Single, widowed, married, divorced, **Widow**  
6. (b) Name of husband or wife **Frank Trau (deceased)** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **January 9, 1854**  
(Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_  
Duration **10 YRS**

8. AGE: Years Months Days If less than one day  
**85** **10** **23** hr. \_\_\_\_\_ min.

**CHRONIC MYOCARDITIS**

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions **NONE**  
(Include pregnancy within 3 months of death)  
Major findings: **NONE**  
Of operations \_\_\_\_\_  
Of autopsy **NO**

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

9. Birthplace **Austria**  
(City, town, or county) (State or foreign country)  
10. Usual occupation **At home**  
11. Industry or business \_\_\_\_\_  
12. Name **John Bruckner**  
13. Birthplace **Austria**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Susanna Poister**  
(City, town, or county) (State or foreign country)  
15. Birthplace **Austria**  
(City, town, or county) (State or foreign country)

MOTHER FATHER

16. (a) Informant's own signature **Rev. Otto Kienker**  
(b) Address **8404 Halls Ferry Rd.**  
17. (a) **Burial** (b) Date thereof **12-5-39**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Wright City, Mo.**  
18. (a) Signature of funeral director **Math Hermann & Son**  
(b) Address **2161 East Fair Ave**  
19. (a) **DEC 4 1939** (b) **J. F. [Signature]**  
(Date received local registrar) (Signature)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) **NO**  
(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) Means of injury \_\_\_\_\_  
23. Signature **Dr. Van Schofer** (M. D. or other) \_\_\_\_\_  
Address **6313 HALLS FERRY RD., CITY** Date signed \_\_\_\_\_

**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.

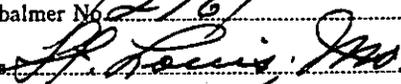
Signed.....



Licensed Embalmer No.....

2967

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.**