

13-40
17-39
X23159

STANDARD CERTIFICATE OF DEATH 791 1003

State File No. _____

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 8663

NOV 16 1940

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis City Hospital #1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 Days
(Specify whether years, months or days)

In this community _____

3. (a) PRINT FULL NAME Nettie Trautmann.

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive unk years

7. Birth date of deceased Dec., 4, 1883
(Month) (Day) (Year)

8. AGE: Years 56 Months 10 Days 15 If less than one day hr. _____ min. _____

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Peter Trautmann

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

14. Maiden name Mari Jaeger

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

16. (a) Informant Mathilda A. Trautmann

(b) Address 2817a Shenandoah

17. (a) burial (b) Date thereof 10-22-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews Cemetery

18. (a) Signature of funeral director _____
6175 Delmar Blvd.

(b) Address _____

19. (a) OCT 21 1940 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 2817a Shenandoah
(If rural, give location)

(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 19, year 1940 hour 10:30 minute _____ P. _____ M. _____

21. I hereby certify that I attended the deceased from October 18, 1940, to October 19, 1940
that I last saw h. alive on October 19, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death:
Endocarditis, Acute
Infarct of Brain
Hypertrophy of Heart
Chronic
Cholelithiasis, Chronic
Obesity

Other conditions (Include pregnancy within 3 months of death):
cause unknown

Major findings:
Of operations None

Of autopsy as above

Duration _____

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? _____
(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 _____

23. Signature _____ (M. D. or other) _____
Address 1515 Lafayette Avenue Date signed 10/21/40

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

MOTHER FATHER

Ever blank 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.....

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, fact should be so stated above.