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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39163**
Registrar's No. **9567**

FILED NOV 25 1946
Registration District No. _____

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Deaconess Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **4129 Chouteau Ave.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Helen M. Trost**
3. (b) If veteran, name war **None**
3. (c) Social Security No. **None**

4. Sex **Female** (5. Color or race **White**)
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Wm. G.**
6. (c) Age of husband or wife if alive **55** years
7. Birth date of deceased **Aug. 9 1892**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
54 2 29 hr. min.

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

10. Usual occupation **Housework**

11. Industry or business _____

MOTHER FATHER

12. Name **Wm. Ingram**
13. Birthplace **St. Louis Mo.**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary Holloran**
15. Birthplace **St. Louis Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Wm. G. Trost**
(b) Address **4129 Chouteau Ave.**

17. (a) **Burial** (b) Date thereof **11 11 46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Sunset Burial Park**

18. (a) Signature of funeral director **Kriegshauser Und. Co.**

(b) Address **4228 So. Kingshighway Bl.**

19. (a) **NOV 8 1946** (b) **J. F. Bredek**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **8th**
year **1946** hour **7:05** minute **A.** M.
21. I hereby certify that I attended the deceased from **October**
7 1946 to **Nov. 8 1946**
that I last saw her alive on **Nov. 8 1946**
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Occlusion** Duration _____

Due to _____
Due to _____

Other conditions: **Hypertensive Heart disease**
(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? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature **J. M. Webb** M. D. or other **M. D.**
Address **4501 1/2 Manchester** Date signed **11-8-46**

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..... *Richard W. Stoverand*

Licensed Embalmer No..... *4007*

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.