

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3211**
Registrar's No. **1091**

FILED FEB 10 1947 **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County **St. Louis**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Mo. Pacific 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)

3. (a) PRINT FULL NAME **Joseph Bernard Treinen**
3. (b) If veteran, name war..... No.....
3. (c) Social Security No.....
4. Sex **M** Color or race **W**
6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife.....
6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased **Dec 31 1877**
(Month) (Day) (Year)

8. AGE: Years **69** Months **I** Days **0**
If less than one day hr. min.

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

10. Usual occupation **R.R. Clark**

11. Industry or business.....

MOTHER FATHER
12. Name **Michael Treinen**
13. Birthplace **Ohio**
(City, town, or county) (State or foreign country)
14. Maiden name **Bernadina Hemmen**
15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Emma Leo**

(b) Address **3660 Wyoming**

17. (a) **Burial** (b) Date thereof **2-3-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Wm Schumacher**
(b) Address **3013 Meramec st.**

19. (a) **FEB 1 1947** (b) **J T Bredek**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis** **17**
(If outside city or town limits, write "RURAL")
(d) Street No. **3660 Wyoming** **1690**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Jan.** day **31**
year **1947** hour **3** minute **45P.** M.
21. I hereby certify that I attended the deceased from **Jan 21 1947** to **Jan 31 1947**
that I last saw h. **alive** on **Jan 31 1947**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cornary occlusion, vent. fibr.**
Due to **chronic myocarditis**

Other conditions **Rt Hemiparesis**
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: **93**
Of operations.....
Of autopsy.....
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 **William W Forby** M. D. or other **700**
Address **2801 S. Grand** Date signed **2-1-47**

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

WILLEY

3108 S. GRAND. ? ←

2602 S. GRAND ? ←

SAT. MORN. ←

Pa. 5172 -

Je 5858 -

Pa 5172

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 Francis Williamson

- - Licensed Embalmer No. 3565

P. O. Address St Louis, 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.