

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **14727**

FILED APR 30 1948

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **3295**

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

**1. PLACE OF DEATH:**

(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:  
St. Johns 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** Wilhelmina Marie Trinkaus

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 Single

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

7. Birth date of deceased Jan. 11th. 1892  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>56</u>	<u>3</u>	<u>9</u>	hr. min.

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

10. Usual occupation Clerk

11. Industry or business Public Service Co.

12. Name August Trinkaus

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

14. Maiden name Bridget Murray

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

16. (a) Informant Mrs. Bridget Trinkaus

(b) Address 5545 Pershing

17. (a) Burial (b) Date thereof: 1/23/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Sullivan Funeral Dir.

(b) Address 2849 North Euclid Ave.

19. (a) APR 22 1948 (Date received local registrar)  
J. F. [Signature] (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County St. Louis

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

(d) Street No. 5545 Pershing  
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No) 0

If yes, name country.....

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month April day 20th.  
year 1948 hour 3:00 minute A. M.

21. I hereby certify that I attended the deceased from February 16, 1948, to April 20, 1948  
that I last saw her alive on April 20, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia, heart failure  
arteriosclerosis

Due to.....

Due to.....

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?.....  
(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 Cecil A. [Signature] (M. D. or other)  
Address [Signature] Date signed 4/24/48

4  
Dr. Carl J. Reis

Humboldt Bldg.

JE. I800

1<sup>00</sup> pm - 5<sup>00</sup> pm Tues or Wed.

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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

*Robert L. Brantman*

Licensed Embalmer No. 3553

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.**