

No. 2
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7-39
47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28283
Registrar's No. 7295

FILED AUG 23 1948
Registration District No. 1818

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
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Barnes Hospital, 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 DAYS (Specify whether
In this community..... years, months or days)

3. (a) PRINT FULL NAME LEONA SPENCE TRIMBLE
3. (b) If veteran, name war..... 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 James B. Trimble 6. (c) Age of husband or wife if alive 55 years
7. Birth date of deceased September 11, 1893
(Month) (Day) (Year)

8. AGE: Years 54 Months 11 Days 7 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business.....

12. Name William Spence

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

14. Maiden name Steele

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

16. (a) Informant J. B. Trimble

(b) Address 7724 Shirley Drive, Clayton 5

17. (a) Cremation (b) Date thereof Aug. 20, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: ~~Burial~~ or cremation Oak Grove Chapel

18. (a) Signature of funeral director Robert J. Ambruster Inc.

(b) Address Clayton Road at Concordia Lane

19. (a) AUG 19 1948 (b) J. F. Bradack
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County CLAYTON
(c) City or town..... (If outside city or town limits, write "RURAL")
(d) Street No. 7724 SHIRLEY DRIVE (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUGUST day 18
year 1948 hour 5 minute P.M.

21. I hereby certify that I attended the deceased from AUG. 7, 1948, to AUG. 18, 1948
that I last saw her alive on AUG. 18, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death metastatic carcinoma of the lungs Duration 1 yr.

Due to adenocarcinoma of the breast 7 yr.

Due to 50

Other conditions..... (Include pregnancy within 3 months of death)

Major findings:
Of operations Adenocarcinoma of the breast
Of autopsy metastatic carcinoma of the lungs

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) (c) Means of injury 0

23. Signature B. Todd Perry M.D. (M. D. or other)

Address Barnes Hospital 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 *Ernest W. Gillers*
Licensed Embalmer No. *4080*

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.