

FILED MAR 22 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

No. 300  
10.48

BIRTH NO. _____		REG. DIST. NO. <u>116</u>		PRIMARY REG. DIST. NO. <u>3026</u>		Registrar's No. <u>46</u>	
1. PLACE OF DEATH a. COUNTY <u>Franklin.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Franklin</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Washington</u>		c. LENGTH OF STAY (In this place) <u>18 days.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Washington "Rural" St. John's</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Francis Hospital.</u>				d. STREET ADDRESS (If rural, give location) <u>R. F. D. #2.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Frederick</u>		b. (Middle) <u>J.</u>		c. (Last) <u>Trentmann.</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Mar. 15th, 1949.</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Oct. 15th, 1870.</u>	
9. AGE (In years last birthday) <u>78</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>0</u>		IF UNDER 6 HRS. Hours <u></u> Mins. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineering.</u>		10b. KIND OF BUSINESS/ OR INDUSTRY <u>Flour Mill.</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Henry Trentmann.</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Nobbe.</u>		14. NAME OF DECEASED'S WIFE <u>Elizabeth Trentmann.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>None.</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Katherine Cridemore</u>		ADDRESS <u>R.F.D. #2.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Prostatitis</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Gonorrhea gall bladder</u> DUE TO (c) <u>Cholelithiasis</u>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Diabetes Mellitus</u>				INTERVAL BETWEEN ONSET AND DEATH  <u>5/58</u>	
19a. DATE OF OPERATION <u>2-26-49</u>		19b. MAJOR FINDINGS OF OPERATION <u>Gonorrhea Pyelitis gall bladder</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-7-49</u> , to <u>2-13-49</u> , that I last saw the deceased alive on <u>2-14-49</u> , and that death occurred at <u>7:9</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>L. M. M. D. Washington Mo</u>				23b. ADDRESS <u>Washington Mo</u>		23c. DATE SIGNED <u>3-15-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Mar. 17, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St. Francis Borgia Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Washington, Missouri.</u>	
DATE REC'D BY LOCAL REG. <u>Mar. 16, 1949</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>990 Nieburg &amp; Vitt, Inc.</u>		ADDRESS <u>Washington, Mo.</u>	

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

RECEIVED  
District Health Officer No. 9,  
District File Number  
MAR 21 1949  
Date Filed

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_  
Student Embalmer

Signed Jerome F. Swoboda  
Licensed Embalmer No. 4507

P. O. Address Washington

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.