No. 300
10.48

FILED JAN 26 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3413

State File No. 0394

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 394

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis, Missouri
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 312 Victor Street.,

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis 2239
d. STREET ADDRESS (If rural, give location) 312 Victor Street.,

3. NAME OF DECEASED (Type or Print)
a. (First) Nellie
b. (Middle) A
c. (Last) Trautman

4. DATE OF DEATH (Month) (Day) (Year) Jan 11, 1952

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Feb 26, 1884
9. AGE (In years last birthday) 67 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY At Home
11. BIRTHPLACE (State or foreign country) DeSoto, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME P. E. Moore
13b. MOTHER'S MAIDEN NAME Nancy Hartle
14. NAME OF HUSBAND OR WIFE Peter Trautman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) Nil
16. SOCIAL SECURITY NO. None
17. INFORMANT'S SIGNATURE OR NAME Helen Madden - 312 Victor Street.,
ADDRESS

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma Colon — INTERVAL BETWEEN ONSET AND DEATH Nov 1-57

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Intestinal Obstruction

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 153X

22. *I hereby certify that I attended the deceased from* Nov 1, 1951, *to* Jan 11, 1952, *that I last saw the deceased alive on* Jan 10, 1952, *and that death occurred at* 3:45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) H. G. Moore M.D.
23b. ADDRESS 977-5018
23c. DATE SIGNED 1-12-52

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal
24b. DATE 1-11-52
24c. NAME OF CEMETERY OR CREMATORY City
24d. LOCATION (City, town, or county) (State) Oran, Missouri

DATE REC'D BY LOCAL REG. JAN 14 1952
REGISTRAR'S SIGNATURE J. Earl Smith M.D.
25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe-4700 Washington Blvd
ADDRESS

(Licensed Embalmer's Statement on Reverse Side)

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.

Student .....
Student Embalmer

Signed J. Wm Burkley

Licensed Embalmer No. 3657

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.