

FILED DEC 16 1954

STANDARD CERTIFICATE OF DEATH

42897
State File No. 10492
Registrar's No.

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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|----------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | c. CITY OR TOWN St. Louis | |
| c. LENGTH OF STAY (In this place) 1 day | | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION: Missouri Baptist Hosp. | | e. STREET ADDRESS (If rural, give location) 3519a Hebert Street 2109 | |

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|-------------------------------------------------------------------------------------------------------|--|-------------------------------------------|---------------------------------------------------------|----------------------------------------------------------------|--|
| 3. NAME OF DECEASED (Type or Print) Emma Mae Trigg a. (First) b. (Middle) c. (Last) | | | 4. DATE OF DEATH 11 - 17 - 1954 (Month) (Day) (Year) | | |
| 5. SEX Fem | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | |
| 8. DATE OF BIRTH 24 - 11 - 1873 | | 9. AGE (In years last birthday) 81 | | 10. IF UNDER 1 YEAR Months Days | |
| 11. BIRTHPLACE Texas | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. IF UNDER 1 YEAR 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 (City and State or Foreign Country) Texas | |

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|-------------------------------------------------------------------------------------------------------------|--|-----------------------------------|--|---------------------------------------------------------------------------------|--|
| 13a. FATHER'S NAME unknown O'Bar | | 13b. MOTHER'S MAIDEN NAME unknown | | 14. NAME OF HUSBAND OR WIFE Dr. Joseph M. Trigg | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Dr. Joseph F. Trigg, 7227 Greenway | |

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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease | | II. OTHER SIGNIFICANT CONDITIONS | | 4 yrs | |
| *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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|-------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? 4200 | |

22. I hereby certify that I attended the deceased from 1 Feb, 1950, to 17 Nov, 1954, that I last saw the deceased alive on 17 Nov, 1954, and that death occurred at 10:15 AM from the causes and on the date stated above.

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|-----------------------------------------------------------------------|--|-------------------------------------|--|-----------------------------------------------------------|--|
| 23a. SIGNATURE (Degree or title) T. S. Drake, M.D. | | 23b. ADDRESS 1149 Taylor St. (S) | | 23c. DATE SIGNED 17 Nov 54 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE 11/20/54 | | 24c. NAME OF CEMETERY OR CREMATORY New Picker Cemetery | |
| 24d. LOCATION (City, town, or county) (State) St. Louis County Mo. | | | | | |

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| DATE REC'D BY LOCAL REG. NOV 18 1954 | | REGISTRAR'S SIGNATURE J. Carl Smith M.D. mjb | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Drehmann-Harrah 1905 Union Blvd. | |
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

Dr. Truman Drake
114 N. Taylor

1 - 5

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.....
Signature of Student Embalmer

Signed... *Warren A. Carver*

Licensed Embalmer No. *353*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.