

FILED OCT 7 - 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31593

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

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8475**

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give town or township) <b>St. Louis</b>	c. LENGTH OF STAY (In this place) <b>Life</b>	c. CITY OR TOWN <b>St. Louis</b>	d. Is Residence within limits of city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>4966 Lilburn Ave.</b>		e. STREET ADDRESS (If rural, give location) <b>4966 Lilburn Ave.</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>LOUISA</b>	b. (Middle) <b>K.</b>	c. (Last) <b>TRAMPE</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Sept. 27, 1955.</b>
-------------------------------------	--------------------------	-----------------------	-------------------------	--------------------------------------------------------------

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Sept. 29, 1870</b>	9. AGE (In years last birthday) <b>84</b>	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) <b>Housework</b>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
--------------------------------------------------------------------------------------------------------------	-----------------------------------------	--------------------------------------------------------------------------	--------------------------------------------

13a. FATHER'S NAME <b>August Rottmann</b>	13b. MOTHER'S MAIDEN NAME <b>Caroline Schuetz</b>	14. NAME OF HUSBAND OR WIFE <b>Henry W. Trampe</b>
-------------------------------------------	---------------------------------------------------	----------------------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Edna Hagerman</b>	ADDRESS <b>4966 Lilburn Ave.</b>
--------------------------------------------------------------------------------------------------------------------	----------------------------------------	-------------------------------------------------------------	----------------------------------

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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Arteriosclerotic heart disease.</b>		INTERVAL BETWEEN DEATH AND DEATH <b>know</b>
	ANTECEDENT CAUSES DUE TO (b) _____ Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>none</b>		

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION <b>420.0</b>	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 checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR _____
-------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------	---------------------------------

22. I hereby certify that I attended the deceased from **9-26-55** <sup>19</sup> to **9-27-55** <sup>19</sup>, that I last saw the deceased alive on **9-26-55** <sup>19</sup>, and that death occurred at **9:00 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Walter H. Spolmerman M.D.</b> (Degree or title)	23b. ADDRESS <b>1515 8th Louis</b>	23c. DATE SIGNED <b>9-27-55</b>
-------------------------------------------------------------------	------------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>9/29/1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Zion Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>
----------------------------------------------------------	----------------------------	---------------------------------------------------------	----------------------------------------------------------------------------

DATE REC'D BY LOCAL REG. <b>SEP 27 1955</b>	REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Calvin F. Feutz</b>	ADDRESS <b>4828 Natural Bridge Blvd.</b>
---------------------------------------------	-------------------------------------------------	---------------------------------------------------------	------------------------------------------

**S.P.** (Licensed Embalmer's Statement on Reverse Side)

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

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..... *Ralph C. Zanders* .....

Licensed Embalmer No..... 42 .....

P. O. Address..... *St. Louis* .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.