

MAY 15 1940
Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 3810

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
City Hospital, #1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 19 Days
(Specify whether years, months or days)

8. (a) PRINT FULL NAME Matilda Trifonoff 615
 8. (b) If veteran, name war nil
 8. (c) Social Security No. nil

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Ben Trifonoff
 6. (c) Age of husband or wife if alive 59 years
 7. Birth date of deceased Novy 3, 1862
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
77 5 21 _____ hr. _____ min.

9. Birthplace DeSalle Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business _____

MOTHER FATHER
 { 12. Name Jacob Alberts
 { 13. Birthplace Illinois
(City, town, or county) (State or foreign country)
 { 14. Maiden name Oldine Brooks
 { 15. Birthplace Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Ben Trifonoff
 (b) Address 3331 Iowa Ave.

17. (a) Burial (b) Date thereof April 27-40
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Val Halla Cemetery

18. (a) Signature of funeral director M. C. Mayhew
 (b) Address 1926 Allen Ave.

19. (a) APR 27 1940
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis 24
(If outside city or town limits, write "RURAL")
 (d) Street No. 3224 S. 13th St.
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 24
 year 1940 hour 8:00 minute _____ P/M.

21. I hereby certify that I attended the deceased from April 6, 19 40 to April 24, 19 40;
 that I last saw her alive on April 24, 19 40;
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis

Due to Arteriosclerosis

Due to _____

Other conditions 92
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____

Of autopsy _____

Duration

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) (e) Means of injury

23. Signature [Signature] (M. D. or other) _____
 Address 1515 Lafayette 1/25/40

WRITE PLAINLY—USE 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

No Embalming

Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

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, above space should be left blank.