

FILED OCT. 24 1944
Registration District No. 3194

Primary Registration District No. 2002

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town University City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Residence: 7746 Bonhomme
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Anna Challin Trask.

3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Eugene L. Trask. 6. (c) Age of husband or wife if alive 81 years

7. Birth date of deceased April 3rd 1866
(Month) (Day) (Year)

8. AGE: Years 78 Months 6 Days 14 If less than one day _____ hr. _____ min.

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

10. Usual occupation At home

11. Industry or business _____

MOTHER FATHER

12. Name William W. Deatherage, I

13. Birthplace Virginia
(City, town, or county) (State or foreign country)

14. Maiden name Frances Challin

15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Eugene L. Trask.

(b) Address 7746 Bonhomme

17. (a) Removal (b) Date thereof 10-18-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Minneapolis, Minn.

18. (a) Signature of funeral director C.R. Lupton & Sons

(b) Address 7233 Delmar Blvd.

19. (a) OCT 19 1944 (b) E. J. McDevitt, M.D.
(Date received local registrar) (Registrar's signature) (Date)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town University City
(If outside city or town limits, write "RURAL")
(d) Street No. 7746 Bonhomme
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 17
year 1944 hour 3:45 minute _____ P. M.

21. I hereby certify that I attended the deceased from July 9
1943 to 10-17 1944
that I last saw her or alive on 10-13 1944
and that death occurred on the date and hour stated above.

Immediate cause of death
Seriously ill; general
Due to _____

Due to 97
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to _____ causes, fill in the following:
(a) Accident, suicide, 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?

(Specify type of place) _____
While at work? _____ (e) Means of injury 0
23. Signature Wm B. Cooney, M.D.
Address 4500 Olive Date signed 10/18

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

NOV 16 1944

NOV 20 1944

Dr. Wm. B. Kountz

4500 Olive St.

FO-3800

Hrs. -

JUL 5 1945

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.....

....., Registered Apprentice No.

working under my personal supervision.

Signed *Bradford A. Miles*

Licensed Embalmer No. *2901*

P. O. Address *University City, 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.