

FILED MAR 5 1945

Registration District No. 317

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Primary Registration District No. 6076

Registrar's No. 068

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2747 N. Hawley Road
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
years, months or days) Six weeks

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2747 N. Hawley Road
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Julia A. Trester

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife John E. Trester 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 2, 1873
(Month) (Day) (Year)

8. AGE: Years _____ Months 8 Days 12 If less than one day _____ min.

9. Birthplace Clinton Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Nurse

11. Industry or business _____

MOTHER FATHER { 12. Name Spormann 9
13. Birthplace Unknown (State or foreign country)
14. Maiden name Unknown 10
15. Birthplace _____ (State or foreign country)

16. (a) Informant Mrs. Ruth Kinnie

(b) Address 3901 1/2 Morning St.

17. (a) Burial (b) Date there: Feb. 16, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clinton Iowa

18. (a) Signature of funeral director Chas. A. Bull

(b) Address 4452 Washington Blvd.

19. (a) 2/15/45 (b) Dr. C. Mc Lanson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 14
year 1945 hour 10 minute P M.

21. I hereby certify that I attended the deceased from 2-11-45
_____ 19____, to 2-14-45
_____ 19____.

that I last saw her alive on 2-11-1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of Bladder Duration 1 year

Due to _____

Due to _____

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

Major findings: _____

Of operations _____

Of autopsy sr-f

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)

23. Signature Dr. C. Mc Lanson (M. D. or other) _____

Address 1114 Mo. Theater Date signed 2-15-45

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

006

7222

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

John Ketter

Licensed Embalmer No.

3880

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.