

## FILED JAN 5 1948 STANDARD CERTIFICATE OF DEATH

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

## 1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
 (b) City or town St. Louis  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
5872 Cates Ave. 1  
 (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 Frank Billon Trowbridge

3. (b) If veteran, name war No. \_\_\_\_\_  
 3. (c) Social Security No. 491-14-5038

4. Sex Male  5. Color or race White  
 6. (a) Single, widowed, married, divorced Widowed  
 6. (b) Name of husband or wife Alice  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
Schneck Trowbridge Dec'd 4/10/10  
 7. Birth date of deceased: 1865-4-8  
 (Month) (Day) (Year)

8. AGE: Years 80 Months 8 Days 11  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min

9. Birthplace St. Louis, Mo.  
(City, town, or county) (State or foreign country)10. Usual occupation Finance officer11. Industry or business Mississippi Valley Trust Co.12. Name John Taylor Trowbridge13. Birthplace St. Louis, Mo.  
(City, town, or county) (State or foreign country)14. Maiden name Virginia Carr Billon15. Birthplace St. Louis, Mo.  
(City, town, or county) (State or foreign country)16. (a) Informant Voorhees S. Trowbridge,(b) Address 5872 Cates Ave.17. (a) Burial (b) Date thereof 12/21/45  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Bellefontaine18. (a) Signature of funeral director Robert J. Ambruster(b) Address Clayton Rd. at Concordia Lane.19. (a) DEC 21 1945 (Date received local Registrar)  
J. F. Bredek (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County \_\_\_\_\_  
 (c) City or town St. Louis  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 5872 Cates Ave.  
 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 19  
 year 1945 hour 4 minute 35 P. M.

21. I hereby certify that I attended the deceased from Oct 1945 to 12/19/45, 19\_\_\_\_  
 that I last saw him alive on 12/18/45, 19\_\_\_\_  
 and that death occurred on the date and hour stated above.

Immediate cause of death Ventricular fibrillation 10 min  
 Due to Hypertensive heart disease 10 yrs

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy No autopsy

Duration

10 min

10 yrs

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 J. W. Dittus (M. D. 26687)  
 Address 3720 Washington Blvd. Date signed 12/20/45

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**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.....

*Robert J. [Signature]*  
Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**