

S. No. 2
M-5-43
5-17-39
X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1021

State File No. _____

FILED JAN 31 1946

Registration District No. _____

Primary Registration District No. 1003

Registrar's No. 228

1. PLACE OF DEATH:

(a) County _____
(b) City or town ST. LOUIS MO.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
CITY ISOLATION HOSPITAL. 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12/15/45 to 1/6/46 (Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 000.
(c) City or town ST. LOUIS 2/17
(If outside city or town limits, write "RURAL")
(d) Street No. 4961 ROBERT 9
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JOHN TRAMPIER

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

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWER

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased JAN. 25th 1856
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
89 10 12 _____ hr. _____ min.

9. Birthplace AUSTRIA H
(City, town, or county) (State or foreign country)

10. Usual occupation NIL

11. Industry or business _____

12. Name JOHN TRAMPIER

13. Birthplace UNKNOWN 9
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace UNKNOWN 0
(City, town, or county) (State or foreign country)

16. (a) Informant CITY INFIRMARY RECORDS 13
(b) Address 5800 ARSENAL ST.

17. (a) Burial (b) Date thereof 1-9-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New SS. Peter & Paul

18. (a) Signature of funeral director Wm C. Maxwell
(b) Address 1926 Allen Avenue

19. (a) JAN 9 1946 (b) J. D. Breda
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN. day 6th
year 1946 hour 11 minute 5 A M.

21. I hereby certify that I attended the deceased from Oct. 18
1945 to 1/6 1946
that I last saw him alive on 1/6 1946
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Myocardial infarction

Due to Arteriosclerotic heart disease

Due to _____

Other conditions Neurotic debility
(Include pregnancy within 3 months of death)

Major findings: ulcers
Of operations _____

Of autopsy _____

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 0

23. Signature John E. Allen (M. D. or other) M.D.

Address 5800 Arsenal Date signed 1/6/46

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Benj. L. Dunbar
Licensed Embalmer No. 2272
P. O. Address 1926 Allen Ave

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.