

FILED NOV 7 1947  
Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. Louis**  
(b) City or town **St. Louis**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution **Deaconess Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **4 days**  
(Specify whether years, months or days)  
In this community.....

2. USUAL RESIDENCE OF DECEASED:

(a) State **Illinois** (b) County **999**  
(c) City or town **O'Fallon**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **118 W State St.**  
(If rural, give location)  
(e) Citizen of foreign country? **N.R.** (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME **Katherine Margaret Trippel**

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

4. Sex **female** 5. Color of race **white** 6. (a) ~~Single, widowed, married,~~ **Married**  
6. (b) Name of husband or wife **Edward Trippel** 6. (c) Age of husband or wife if alive **59** years  
7. Birth date of deceased **May 25 1892**  
(Month) (Day) (Year)

8. AGE: Years **55** Months **5** Days **0** If less than one day hr. min.

9. Birthplace **Clinton County Illinois**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**  
**Own home**

11. Industry or business **Herman Ennen**

12. Name **Herman Ennen** 13. Birthplace **Germany**  
(City, town, or county) (State or foreign country)

14. Maiden name **Margaret Rippen**

15. Birthplace **St. Clair Co Illinois**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Edward Trippel**  
(b) Address **O'Fallon, Illinois**

17. (a) **Removal** (b) Date thereof **10/26/47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **O'Fallon, Ill.**

18. (a) Signature of funeral director **The Thielenburg**  
(b) Address **223 W 1st, O'Fallon, Ill.**

19. (a) **OCT 28 1947** (b) **J. F. Bredebeck**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **25th**  
year **1947** hour **11th** minute **10** P.M.

21. I hereby certify that I attended the deceased from **Oct. 21** 1947, to **Oct. 25** 1947;  
that I last saw **her** alive on **Oct. 25** 1947;  
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Thrombosis** **10 days**  
Due to **Arterio Sclerosis**  
**Heart Disease** **3**

Due to.....  
Other conditions.....  
(Include pregnancy within 3 months of death) **92**

Major findings:  
Of operations.....  
Of autopsy.....

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?.....  
(Specify type of place)  
While at work?..... (e) Means of injury.....  
23. Signature **P. P. Sheffer** (M. D.)  
Address **634 N. Grand St. O'Fallon, Mo.** Date signed **10-28-47**

PHYSICIAN  
Underline the cause of which death should be charged statistically.

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

MOTHER FATHER

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 Me

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

Signed Elton R. Remick

Licensed Embalmer No. 4283

P. O. Address 0) Fallon, Illinois

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.