

FILED MAR 11 1949

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6760**
Registrar's No. **1988**

BIRTH NO. _____ REG. DIST. NO. **312** PRIMARY REG. DIST. NO. **1000**

1. PLACE OF DEATH a. COUNTY St. Louis Mo.		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE 5545 Pershing COUNTY Mo.	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis Mo.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 5545 Pershing ave.		d. STREET ADDRESS (If rural, give location) 5545 Pershing ave.	
3. NAME OF DECEASED (Type or Print) BRIDGET TRINKAUS. a. (First) _____ b. (Middle) _____ c. (Last) _____			4. DATE OF DEATH (Month) 2 (Day) 28 (Year) 49
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH 5/15/1867
9. AGE (In years last birthday) 81		IF UNDER 1 YEAR Month 1 Day 15	IF UNDER 24 HRS. Hour 11 Min. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) Ireland.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Murray	
13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND August Trinkaus	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Marcelline		ADDRESS 5545 Pershing	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) Arterio-Sclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 331X	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) St. Louis (COUNTY) _____ (STATE) Mo.	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from 1947 , to Feb 28, 1949 , that I last saw the deceased alive on Feb 28, 1949 , and that death occurred at 2 P. m., from the causes and on the date stated above.			
23a. SIGNATURE Alfred M. Augustenbach M.D. (Degree or title)		23b. ADDRESS 6200 Hoffman Ave.	
23c. DATE SIGNED Mar 1, 1949		24a. BURLAL CREMATION, BURIAL, OR OTHER (Specify) Burial	
24b. DATE 3/3/49		24c. NAME OF CEMETERY OR CREMATORY Calvary Cem.	
24d. LOCATION (City, town, or county) St. Louis Mo. (State) _____		DATE REC'D BY LOCAL REG. MAR 2 1949	
REGISTRAR'S SIGNATURE J. B. Lasater		25. FUNERAL DIRECTOR'S SIGNATURE Sullivan Funeral Directors ADDRESS _____	

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

Dr. Langenbach.
6200 Hoffman St. 1177
Tuesday A.M.

Rec. Te 3-5613

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.....

Student Embalmer No.

working under my personal supervision.

Signed

Robert L. Brinkman

Licensed Embalmer No. 3563

Signed

Student Embalmer

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, fact should be so stated above.