

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14932**
3756

FILED APR 30 1956

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) --a. STATE Missouri b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 72 yrs.		e. STREET ADDRESS (If rural, give location) 709 Pope Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION De Paul Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) FRED	b. (Middle) F.	c. (Last) TRUMPOLD	4. DATE OF DEATH (Month) (Day) (Year) April 15, 1956.
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH March 23, 1881.	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician	10b. KIND OF BUSINESS OR INDUSTRY Newspaper	11. BIRTHPLACE (City and State or Foreign Country) Germany	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Robert Henry Trumpold	13b. MOTHER'S MAIDEN NAME Marie Schiller	14. NAME OF HUSBAND OR WIFE Ida P. Trumpold
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 490-01-1587	17. INFORMANT'S SIGNATURE OR NAME Robert R. Trumpold	ADDRESS 6110 North Pointe Bl.
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Insufficiency		
	ANTECEDENT CAUSES Coronary insufficiency Ascribed conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Pneumonia -Pneumonia DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death. Tumor of Brain			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 420.1	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 4-15-56 m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4-15-56 4-15-56
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22. I hereby certify that I attended the deceased from **April 15, 1956**, to **April 15, 1956**, that I last saw the deceased alive on **April 16, 1956**, and that death occurred at **12:45P** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) A.H. Sewing M.D.	23b. ADDRESS 2342 St. Louis Ave.	23c. DATE SIGNED 4/16
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24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	24b. DATE 4/16/56.	24c. NAME OF CEMETERY OR CREMATORY Oak Grove Crematory	24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
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DATE REC'D BY LOCAL REG. APR 16 1956	REGISTRAR'S SIGNATURE J. Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS CALVIN F. FEUTZ FUNERAL HOME, INC. 4828 Natural Bridge Blvd. St. Louis 15, Mo.
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S.O. (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY--USING 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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *Ralph C. Linder*

Licensed Embalmer No. 427

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.