URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59-042633

FILED VS DEC 7 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 211043

STATE FILE NUMBER

MENDED

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Length of stay in 1b

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Lutheran Hospital — Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY

c. CITY OR TOWN: St. Louis — Inside Limits Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location): 6235 Itaska St. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First LOUISE — Middle — Last TRIPPE

4. DATE OF DEATH: Month Nov. Day 28 Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH: 10-27-1877

9. AGE (last birthday): 82 — IF UNDER 1 YEAR: Months Days — IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (City and state or country): St. Louis, Mo.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Unknown Feldhaus

13b. MOTHER'S MAIDEN NAME: Unknown

14. NAME OF HUSBAND OR WIFE: Late Frank Trippe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO.

17. INFORMANT: Margaret Trippe — Address: 6235 Itaska St.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): ARTERIOSCLEROTIC HEART DISEASE — INTERVAL BETWEEN ONSET AND DEATH: YEARS

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): GENERALIZED ARTERIOSCLEROSIS — YEARS

DUE TO (c): 420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION — COUNTY — STATE

21. I attended the deceased from NOV 1, 1959, to NOV 28, 1959 and last saw her/him alive on NOV 28, 1959

Death occurred at 10:05 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): George A. Doman MD

22b. ADDRESS: 5203 Chippewa

22c. DATE SIGNED: 11/30/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE: Nov. 30, 1959

23c. NAME OF CEMETERY OR CREMATORY: Missouri Crematory

23d. LOCATION (City, town, or county) (State): St. Louis, Mo.

24. FUNERAL DIRECTOR: Kriegshauser — ADDRESS: 4228 S. Kingshighway

25. DATE RECD. BY LOCAL REG.: NOV 30 1959

26. REGISTRAR'S SIGNATURE: Hand Smith M.D. MJB

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed R. W. Stoveand

Signature of Student Embalmer

Licensed Embalmer No. 4067

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp 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.