

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. NOV. 9 1960 317

60-040550  
STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. 547 Registrar's No. 3069

<b>1. PLACE OF DEATH</b> a. COUNTY <u>St. Louis</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond Heights</u> Length of stay in 1b <u>3 yrs</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> COUNTY <u>St. Clair</u> c. CITY OR TOWN <u>Belleville</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>7404 Hoover</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>132 No. 8th</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

<b>3. NAME OF DECEASED</b> (Type or print) First <u>Elizabeth</u> Middle <u>Trentmann</u> Last <u>Trentmann</u>	<b>4. DATE OF DEATH</b> Month <u>Oct.</u> Day <u>21</u> Year <u>1960</u>
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<b>5. SEX</b> <u>female</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>1-27-1874</u>	<b>9. AGE (last birthday)</b> <u>86</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own home</u>	<b>11. BIRTHPLACE</b> (City and state or country) <u>St. Clair County Ill.</u>	<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>
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<b>13a. FATHER'S NAME</b> <u>Henry Schloeffler</u>	<b>13b. MOTHER'S MAIDEN NAME</b> <u>Elizabeth ?</u>	<b>14. NAME OF HUSBAND OR WIFE</b> <u>Henry Trentmann (Decsd)</u>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	<b>16. SOCIAL SECURITY NO.</b> <u>None</u>	<b>17. INFORMANT</b> <u>Francis Trentmann</u> Address <u>Belleville, Ill. 132 No. 8th</u>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH
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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. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
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<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m.	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>
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<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE
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21. I attended the deceased from July 1955 to October 21, 1960 and last saw her/him alive on October 20, 1960  
 Death occurred at 4-PM on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <u>Thomas F. Scumacher, M.D.</u>	<b>22b. ADDRESS</b> <u>2264 S. Conydon St. Saint</u>	<b>22c. DATE SIGNED</b> <u>10-22-60</u>
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<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Removal</u>	<b>23b. DATE</b> <u>10-24-60</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mount Carmel</u>	<b>23d. LOCATION</b> (City, town, or county) (State) <u>Belleville, Ill.</u>
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<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Remmer Funeral Home Belleville, Ill.</u>	<b>25. DATE RECD. BY LOCAL REG.</b> <u>10-22-60</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>John E. Murphy M.D.</u>
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DOCUMENT

MEDICAL CERTIFICATION

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  
or by Not embalmed Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Geo. Rimmer

Licensed Embalmer No. 2314

P. O. Address Belleville, I

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.