WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

42405

PLACE OF DEATH

County Ste Genevieve

Township Jackson Registration District No. 780 File No.

or Village Bloomsdale Primary Registration District No. 6028 Registered No. 72

or City Mo (No. St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Ferdinand Eisenbies

PERSONAL AND STATISTICAL PARTICULARS

SEX Male

COLOR OR RACE White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widowed

DATE OF BIRTH Aug (Month) 3 (Day) 1839 (Year)

AGE 77 yrs. 4 mos. 4 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Farming

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Saha Baden Germany

PARENTS

NAME OF FATHER Fredoline Eisenbies

BIRTHPLACE OF FATHER (City or town, State or foreign country) Germany

MAIDEN NAME OF MOTHER Unknown

BIRTHPLACE OF MOTHER (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jos. F. Eisenbies

(ADDRESS) Bloomsdale Mo

Filed 12/31, 1916. A. E. Meyer REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec (Month) 7 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 2nd, 1916, to Dec 7, 1916, that I last saw him alive on Dec 6, 1916, and that death occurred, on the date stated above, at 7:00 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia ~~Broncho~~

(Duration) ___ yrs. ___ mos. 7 ds.

Contributory (SECONDARY) ___ (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) Frank A Elders M. D.

Dec 7, 1916 (Address) Bloomsdale Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL Bloomsdale Cem

DATE OF BURIAL Dec 8, 1916

UNDERTAKER Joseph Brischler

ADDRESS Bloomsdale Mo

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALT
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County.....

Township ..... Registration District No..... File No.....

or

Village..... Primary Registration District No..... Registered No.....

or

City .....(NO....., ...St.;.....Ward)

[If death occurred i hospital or institut give its NAME inst of street and number]

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., 1.....
(Month) (Day) (Year)

AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191...., ...

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., 191.
(Month) (Day) (Ye

I HEREBY CERTIFY, that I attended deceased fr

....., 191...., to....., 191...

that I last saw h.....alive on....., 191...

and that death occurred, on the date stated above, at.....

The CAUSE OF DEATH* was as follows:

.....

.....

.....(Duration).....yrs.....mos.....

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....mos.....

(Signed)..... M.

....., 191.... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, s (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191
UNDERTAKER	ADDRESS