

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

Do not use this space.

16998

1. PLACE OF DEATH

County Jackson Registration District No. 398
 Township St. Louis Primary Registration District No. 55-54
 City St. M. Washington No. 526 Glenwood St. _____ Ward _____

File No. _____

Registered No. 199

2. FULL NAME

Charles N. Eifert
 (a) Residence. No. 526 Glenwood St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred 23 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Louise - Eifert

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 14, 1859

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ____ hrs. or ____ min. 68 8 15

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work K.O. Strap Co.
 (b) General nature of industry, business, or establishment in which employed (or employer) Co.
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Indiana

10. NAME OF FATHER

John Eifert

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Indiana

12. MAIDEN NAME OF MOTHER

Ellen

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Indiana

14.

INFORMANT Hubert Eifert
 (Address) 526 Glenwood

15.

FILED May 28 1928 F. H. Leok
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 19 1928

17. I HEREBY CERTIFY that I attended deceased from May 7 to May 17 25 1928
 that I last saw him alive on May 18 1928, and that death occurred, on the date stated above, at 4:07 p.m.

11. THE CAUSE OF DEATH* WAS AS FOLLOWS:

"Blood Poison" Strepto-coccal Infection following injury to hand
 (a) Streptococci (duration) yrs. mos. da. 14
 (b) Serulity + Arterio-sclerosis (duration) yrs. mos. da. (3)

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH. no. DATE OF _____

WAS THERE AN AUTOPSY. no.

WHAT TEST CONFIRMED DIAGNOSIS Clinical + Laboratory

(Signed) J. Magee, M. D.

May 19 1928 (Address) Independent Ave Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

St. M. Washington DATE OF BURIAL May 21 1928

20. UNDERTAKER

Mrs C. L. Porter ADDRESS 418 Brook

WHITENBERGER, WITH UNFADING INK---THIS IS A PERMA

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.

RECORDS
JAN 22 1945
OR should be
affid. Exemption
USP & DEATH in plain text
M. - Every hour of information
JAN 22 1945

Handwritten: 142

Handwritten: till 5 pm

JAN 22 1945

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jackson
Township Blue
City (No.) (No.) (No.) St. Ward)

Registration District No. 398
Primary Registration District No. 8-5-54

File No.
Registered No. 199

2. FULL NAME

Charles H. Eipert

(a) Residence. No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILE July 28 1928 H. Cook REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 19 1928

17. I HEREBY CERTIFY That I attended deceased from 19....., 19....., 19....., and that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above.....

THE CAUSE OF DEATH WAS AS FOLLOWS:
Blood Poison - Streptococci Infection following injury to hand working in yard to which I had been taken in hospital.
CONTRIBUTORY (SECONDARY) Semility & Otitis Media

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) TJB, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
20. UNDERTAKER ADDRESS

FADING INK - RE-PRINTED

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PREPARED BY LAW

SUPPLEMENTARY

5-14998