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

Do not use this space.
34562

1. PLACE OF DEATH
County: St. Charles — Registration District No.: 758
Township: Cuivre — Primary Registration District No.: 5999
City: St. Paul (No. ..... St. ..... Ward)

File No. .....
Registered No. 47

2. FULL NAME: Mrs. Elizabeth H. Eisenbath
(a) Residence. No. St. Paul St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 45 yrs. ✓ mos. — ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
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: A. C. Eisenbath

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Nov. 19 – 1860

7. AGE

Years	Months	Days	If LESS than 1 day ..... hrs. or ..... min.
67	11	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (CITY OR TOWN): St. Charles Co.
(STATE OR COUNTRY): Mo.

PARENTS
10. NAME OF FATHER: John Haselmann
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Germany
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER: Fleur
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): St. Charles Co.
(STATE OR COUNTRY): Mo.

14. INFORMANT: Geo. A. C. Eisenbath
Address: St. Paul Mo.

15. FILED 10/26, 1928 J. M. Jeffries M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Oct. 24 1928

17. I HEREBY CERTIFY, That I attended deceased from Dec 28, 1924, to Oct 24 1928, that I last saw her alive on Oct 23, 1928, and that death occurred, on the date stated above, at 8:40 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage 9 m
2 d Stroke
..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (SECONDARY): Interstitial nephritis
..... (duration) Indefinite yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? ✓
IF NOT AT PLACE OF DEATH? ✓
DID AN OPERATION PRECEDE DEATH? ✓ DATE OF ✓
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) L. H. Hoemmer, M. D.
, 19 (Address) O'Fallon 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. Paul Mo.
DATE OF BURIAL: 10/26 1928

20. UNDERTAKER: E. A. Keithly
ADDRESS: O'Fallon Mo.

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.

THIS IS A PERMANENT RECORD