

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

Do not use this space.

<sup>70</sup>  
MAY 7 1937

14931

1. PLACE OF DEATH

County..... Registration District No. **791**  
Township..... Primary Registration District No. **1008**  
City **St. Louis** (No. **3806 Utah Place**) St. .... Ward)

2. FULL NAME **James H. Eisenhour**

(a) Residence No. **3806 Utah Place** St., **16** Ward. (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 **Male**  
4. COLOR OR RACE **White**  
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Married**  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Kate Eisenhour**  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Unknown**  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
**Abt. 70**

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **Night Watchman**  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. **Private**  
10. Date deceased last worked at this occupation (month and year).....  
11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) **York**  
(STATE OR COUNTRY) **Pennsylvania**

13. NAME **Unknown**

14. BIRTHPLACE (CITY OR TOWN) **Unknown**  
(STATE OR COUNTRY)

15. MAIDEN NAME **Unknown**

16. BIRTHPLACE (CITY OR TOWN) **Unknown**  
(STATE OR COUNTRY)

17. INFORMANT **Nellie Mueller**  
(ADDRESS) **3806 Utah Place**

18. BURIAL, CREMATION, OR REMOVAL  
PLACE **Mo. Crematory** DATE **Apr. 30th. 1937**

19. UNDERTAKER **Wacker-Helderle**  
(ADDRESS) **2531 S. Broadway**

20. FILED **J. Brebeck**  
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **April, 27th. 1937**

22. I HEREBY CERTIFY, That I attended deceased from **July 16** 19**25**, to **April 27** 19**37**  
I last saw **him** alive on **April 26** 19**37**. Death is said to have occurred on the date stated above, at **9.50 A.M.**

The principal cause of death and related causes of importance were as follows:  
**Chronic myocarditis with coronary thrombosis**  
Date of onset **1934**  
**Arterio Sclerosis** ?

Name of operation..... Date of.....  
What test confirmed diagnosis? **Clinical & Physical** Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide?..... Date of injury....., 19.....  
Where did injury occur?..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....  
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?  
If so, specify.....

(Signed) **S. Henry C. Gaul**, M. D.  
(Address) **2907 1/2 Cherokee St.**

APR 28 1937

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