

APR 12 1939

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

8164
Do not use this space.

1. PLACE OF DEATH

(a) County..... / Registration District No. **791**
 (b) Township..... Primary Registration District No. **1003**
 (c) City **St. Louis** (d) Street No. **City Hospital No. 1** Registered No. **1929**
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

D. 16900
 2. PRINT FULL NAME **460 Jacob Eiler**

(a) Residence, No. **8500 Water** St. **1** (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Separated**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **2/27/39** 19

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

22. I HEREBY CERTIFY, That I attended deceased from **2/18/39** 19 to **2/27/39** 19

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Aug 17, 1863**

I last saw him live on **2/27/39** 19. Death is said to have occurred on the date stated above, at **4:45 p.**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. **75 6 10**

The principal cause of death and related causes of importance were as follows:

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

Lymphosarcoma
Primary seat retroperitoneal
 Date of onset

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis, Missouri**

Other contributory causes of importance:

FATHER 13. NAME **Henry Eiler**

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy? **yes**

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

MOTHER 15. MAIDEN NAME **Johnanna Kesten**

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)

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

Specify whether injury occurred in industry, in home, or in public place.

17. INFORMANT (ADDRESS) **Hosp. Info M. Kent**

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

18. BURIAL, CREMATION, OR REMOVAL PLACE **St. Trinity Cem.** DATE **March 2, 1939**

24. Was disease or injury in any way related to occupation of deceased? **no**
 If so, specify.....

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **C. Hoffmeister U.A.L. Co. 7314 S. Broadway**

(Signed) **ED Deuk** M. D.
 (Address) **City Hospital No. 1**

20. FILED **MAR 1 1939** **J. B. Budick** Local Registrar.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

STATEMENT TO CEMETARY BOARD
BY LICENSED EMBALMER
REGARDING BURIAL

MADE THIS _____ DAY OF _____ 19____

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, _____

or by _____

Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Licensed Embalmer No. **3871**

P. O. Address **7814 S. Broadway**

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.