

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
REC'D AUG 11 1939

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 23757
Registrar's No. 6030

Registration District No. 791 Primary Registration District No. _____

1. PLACE OF DEATH: 1003
(a) County 1
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Luthern Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Emelia Eilers 462
8. (b) If veteran, name war _____ 8. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Christian W. Eilers 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased December 19, 1879
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>59</u>	<u>6</u>	<u>19</u>	hr. _____ min.

9. Birthplace Saxony Germany
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife 6

11. Industry or business _____
12. Name Unknown Kaffer 6
18. Birthplace Unknown Germany 6
(City, town, or county) (State or foreign country)
14. Maiden name Katherine Katzman
15. Birthplace Saxony Germany
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Henry Eilers
(b) Address Edwardsville Illinois

17. (a) Burial (b) Date thereof July 10, 1939
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Edwardsville Illinois

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blv.

19. (a) 8 1939 (Date of local registrar) J. B. ... (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Illinois (b) County 2
(c) City or town Edwardsville NR
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 8
year 1939 hour 5 a.m. minute _____ M.
21. I hereby certify that I attended the deceased from June 2, 1939 to July 8, 1939
that I last saw her alive on July 8, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Pachy-meningitic spinal block
Due to arteriosclerosis
and degeneration of brain
Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)
Major findings: _____
Of operations _____
Of autopsy _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

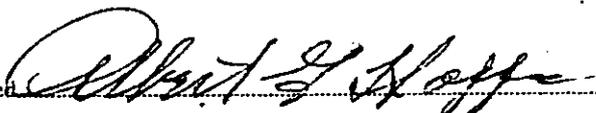
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature A. M. B. Kayat (M. D. or other) NR
Address 600 S. King Highway Date signed 7-1-39

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. 2971.....

P. O. Address.....

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

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