

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH: **2**
(a) County _____
(b) City or town **St Louis, Mo.**
(c) Name of hospital or institution: **XX 2843 Cass Ave**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **XX**
In this community **17 years,** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: **1**
(a) State **Missouri** (b) County _____
(c) City or town **St Louis,** **20**
(If outside city or town limits, write "RURAL")
(d) Street No. **2843 Cass, Ave,**
NO PHYSICIAN IN ATTENDANCE
(e) If foreign born, how long in U. S. A.? **41 yrs, 1 Day** years.

3. (a) PRINT FULL NAME **James Eberhardt, 166**
3. (b) If veteran, name war _____ 3. (c) Social Security No. **333-03-4426**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **NOV** day **13 th,** year **1939.** hour **10:** minute **25.A.M.**
21. I hereby certify that I attended the deceased from _____, 19____; to _____, 19____; that I last saw h_____ alive on _____, 19____ and that death occurred on the date and hour stated above.

4. Sex **Male** 5. Color or race **Col** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Alice Eberhardt,** 6. (c) Age of husband or wife if alive **38,** years
7. Birth date of deceased **February 12th, 1898**
(Month) (Day) (Year)

Immediate cause of death **Ruptured Aortic Aneurysm;** Duration _____
Due to _____
Due to _____

8. AGE: Years **41,** Months **9,** Days **1** If less than one day _____ hr. _____ min.

9. Birthplace **Arnoldsville, Georgia.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Chain-man, Granite City Steel Co,**
Granite City Steel Co,

11. Industry or business _____
12. Name **Henry Pope, unknown**
13. Birthplace **Georgia, unknown**
14. Maiden name **Georgia Eberhardt,**
15. Birthplace **Georgia.**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Alice Eberhardt**
(b) Address **2843 Cass, Ave, St Louis, Mo.**

17. (a) **Burial** (b) Date thereof **Nov 19th, 1939**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Washington Park Cem**

18. (a) Signature of funeral director **W. H. Hester,**
(b) Address **2812, Thomas Street, St Louis, Mo.**

19. (a) **NOV 15 1939** (b) **J. F. Burkholder**
(City or town) (Month) (Day) (Year) (Signature)

Major findings: **Of operations**
Of autopsy _____
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) Means of injury _____
23. Signature **Joseph M. Quinn** (M. D. or other) _____
Address **Deputy Coroner** Date signed _____

PHYSICIAN
Underline the cause to which death should be charged statistically

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.

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

Signed

M. H. Hovatter
Licensed Embalmer No. 2266

P. O. Address 2812 Thomas St

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.

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

37884
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No.....
 (b) Township..... Primary Registration District No.....
 (c) City..... (d) Street No.....
 (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.

2. PRINT FULL NAME

(a) Residence, No. 2843 CASS AVE St. 7
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>M.</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>ALICE EBERHARDT.</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)				
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.		11. Total time (years) spent in this occupation.	
	9. Industry or business in which work was done, as saw mill, bank, etc.			
	10. Date deceased last worked at this occupation (month and year)			
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)				
FATHER	13. NAME			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)			
MOTHER	15. MAIDEN NAME <u>GEORGIA EBERHARDT.</u>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)			
17. INFORMANT (ADDRESS)				
18. BURIAL, CREMATION, OR REMOVAL				
PLACE DATE 19				
19. FUNERAL DIRECTOR (NAME) (ADDRESS)				
20. FILED <u>17/15/39</u> 19. <u>J. D. Bredish</u> Local Registrar.				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 19

22. I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....
 I last saw h..... alive on..... 19..... Death is said to have occurred on the date stated above, at..... m.
 The principal cause of death and related causes of importance were as follows:
 Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....
 What test confirmed diagnosis?..... 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)....., M. D.
 (Address).....

SUPPLEMENTARY

K. 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.

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.....

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.