No. 2
11-10-39
17-39

FILED MAY 19 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 19233

Registration District No. 336

Primary Registration District No. 6131

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Shannon

(b) City or town Teresita (rural) Monroe

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: /

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community approx'. 25 years

years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Shannon

(c) City or town Teresita - Rural

(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.? 0 years.

3. (a) PRINT FULL NAME Mina Louisa Eisenhauer

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife P. J. Eisenhauer

6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased January (Month) 24, (Day) 1883 (Year)

8. AGE: Years 60 Months 2 Days 24 If less than one day hr. min.

9. Birthplace Fayettville, (City, town, or county) Illinois (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name August H. Fritz
13. Birthplace Fayettville, (City, town, or county) Illinois (State or foreign country)

MOTHER
14. Maiden name Anna Geyer
15. Birthplace Cincinatti (City, town, or county) Ohio (State or foreign country)

16. (a) Informant Mr. P. J. Eisenhauer

(b) Address Teresita, Missouri

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 4/21/43 (Month) (Day) (Year)

(c) Place: burial or cremation Pleasant Grove cemetery

18. (a) Signature of funeral director J C Burns

(b) Address Willow Springs, Mo.

19. (a) 4-22-43 (Date received local registrar) (b) Frank Hyde M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 18 year 6 hour 30 minute A M.

21. I hereby certify that I attended the deceased from Apr. 18, 19__, to 1943; that I last saw her alive on April 18 1943; and that death occurred on the date and hour stated above.

Immediate cause of death Functional Diseases of the Heart.

Due to History of long series of Sickness & Operations.

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature W. W. Cottingham (M. D. or other) DO

Address Mountain View, Mo. Date signed 4/18/43

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 8

District File Number 3-4393

Date Filed 3-17-43

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 J. C. Burns

Licensed Embalmer No. 3379

P. O. Address Willow Springs, Mo.

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.

(Licensed Embalmer's Statement on Reverse Side)

S. No. 2B
M—8-21-41
I X29288

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 336 Primary Registration District No. 6131 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Shannon

(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Mina Louisa Eisenhauer

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Jan (Month) 24 (Day) 1883 (Year)

8. AGE: Years 60 Months 2 Days 24 If less than one day min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

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

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 28
year 1943 hour minute 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.

Immediate cause of death Functional disease of the heart. Chronic Endocarditis

Due to History of longevity of sickness & operation

Due to

Other conditions
(Include pregnancy within 3 months of death) 92d

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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature W. F. W. Cottingham (M. D. or other) D.O.
Address Mountain View Date signed 4/18/43

S-19233