

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **247**

247

FILED JAN 16 1945

Registration District No. **318**Primary Registration District No. **1003**Registrar's No. **71**

71

1. PLACE OF DEATH:

(a) County St. Louis Mo
 (b) City or town St. Louis Mo
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Johns Hosp
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
 (Specify whether
 In this community Life
 years, months or days)

3. (a) PRINT FULL NAME Dr Edward H Eyerman3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, Widowed
 6. (b) Name of husband or wife Josephine B 6. (c) Age of husband or wife if alive 2 years
 7. Birth date of deceased Jan 2 1875
 (Month) (Day) (Year)

8. AGE: Years 70 Months 0 Days 0 If less than one day hr. min.9. Birthplace St. Louis Mo
(City, town, or county) (State or foreign country)10. Usual occupation Physician

11. Industry or business

12. Name William Eyerman
 13. Birthplace Germany
 (City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace Germany
 (City, town, or county) (State or foreign country)

16. (a) Informant Edward L Eyerman(b) Address 2924 So. Grand Ave17. (a) Burial (b) Date thereof 1 5 75
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation New St. Peter Paul18. (a) Signature of funeral director KRIEGSHÄUSER(b) Address 4228 So. Kingshighway19. (a) JAN 4 1945 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 17
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL") 169
 (d) Street No. 2924 So. Grand Ave
 (If rural, give location)
 (e) Citizen of foreign country? (Yes or No) No
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 2
year 1945 hour 3.40 AM minute M.21. I hereby certify that I attended the deceased from Dec 26 1944 to Jan 2 1944
that I last saw him alive on Dec 31 1944
and that death occurred on the date and hour stated above.Immediate cause of death Coronary Thrombosis Duration 2 weeksDue to Hypertensive Cardio Vas. Disease yrs? 93

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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 Ratusella (M. D. or other) ✓
Address 3720 Washington Date signed 1/4/45

(Licensed Embalmer's Statement on Reverse Side)

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

~~Dr. O. P. Falk~~

A. C. Munnick

Humboldt County

Trinidad

3700 Washington

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.....

Edwin O. M. Bennett

Licensed Embalmer No.....

3024

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, fact should be so stated above.