V. S. No. 2
00M—5-43
Rev. 5-17-39
No. I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 27 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2439

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 427

1. PLACE OF DEATH:

(a) County
(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: St. Louis City Hospital-Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4416 Ashland Ave.,
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME GEORGE EISE

3. (b) If veteran, name war No

3. (c) Social Security No. ?

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife May Eise

6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased Feb. 24, 1868. (Month) (Day) (Year)

8. AGE: Years 78 Months 10 Days 19 If less than one day hr. min.

9. Birthplace St. Louis, Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Saleman

11. Industry or business

MOTHER FATHER

12. Name John Eise

13. Birthplace Unkown (City, town, or county) (State or foreign country)

14. Maiden name Unkown

15. Birthplace Unkown (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. May Eise
(b) Address 4416 Ashland Ave.,

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 16/47. (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Jos. W. Clark,
(b) Address 1125 Hodiamont Ave.,

19. (a) JAN 14 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 13th year 1947 hour 11:20 minute P M.

21. I hereby certify that I attended the deceased from 1/10/47, 19..., to 1/13/47, 19...; that I last saw him alive on 1/13/47, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cardiac Decompensation due	2 years
to Cerebrovascular generalized	2 years
Due to	
Due to	
Other conditions Bronchopneumonia (Include pregnancy within 3 months of death)	4 days

Major findings:
Of operations
Of autopsy Bronchopneumonia, Cardiomyopathy

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 Gilbert C. Sweet (M. D. or other) Undersigned
Address 1515 LAFAYETTE 1/14/47

(Licensed Embalmer's Statement on Reverse Side)

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 Alfred F. Boedeker

Licensed Embalmer No. 2663

P. O. Address 1125 Hodiamont Ave.

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.