

FILED OCT 19 1947
National Office of Vital Statistics
Registration District No. **18**

Primary Registration District No. **1003**

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. Starloff**
(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)

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. **6405 Hancock Ave.**
(If rural, give location)

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

If yes, name country.....

3. (a) PRINT FULL NAME..... **THOMAS EISENHOFFER**

3. (b) If veteran, name war..... **None**

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..... **Adele**

6. (c) Age of husband or wife if alive..... **65** years

7. Birth date of deceased..... **Oct. 9 1880**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	66	11	9hr.min.

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

10. Usual occupation..... **Foreman**

11. Industry or business..... **Daybrite Co.**

12. Name..... **Unknown**

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

14. Maiden name..... **Unknown**

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

16. (a) Informant..... **Adele Eisenhoffer**

(b) Address..... **6405 Hancock Ave.**

17. (a) **Burial** (b) Date thereof..... **9-22-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... **Resurrection Cem.**

18. (a) Signature of funeral director..... **Kriegshauser Und. Co.**

(b) Address..... **4228 So. Kingshighway Bl.**

19. (a) **SEP 19 1947** (b) **J. B. Bealeck**
(Date issued local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... **Sept.** day..... **18th**
year..... **1947** hour..... **1:30** minute..... **A** M.

21. I hereby certify that I attended the deceased from **9/16/47**
....., 19....., to **Sept. 18th 1947**;
that I last saw him alive on **Sept. 18th 1947**;
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Asphyxiation due to cerebral aneurysm

Due to.....
Cerebral aneurysm

Due to.....
Hypertension, essential

Other conditions.....
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations.....

Of autopsy.....
Cerebral aneurysm & hypertension

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) Cause of injury..... **Power transmission**

23. Signature..... **Power** **M.D.**
1515 Lafayette **9/18/47**
Address..... Date signed.....

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

MOTHER FATHER

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

Richard H. Stoverud

Licensed Embalmer No. *4007*

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.