

FILED APR 10 1948

Registration District No. 2047

Primary Registration District No. 2047

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County St. Charles  
(b) City or town Fossil Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(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

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County St. Charles  
(c) City or town Fossil Mo.  
(If outside city or town limits, write "RURAL") 92  
(d) Street No. \_\_\_\_\_ (If rural, give location) 00  
(e) Citizen of foreign country? No (Yes or No) 00  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Emily Eliza Eldena  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 3 day 30  
year 48 hour 2:30 minute 17 M.  
21. I hereby certify that I attended the deceased from April  
1947 to March 1948  
that I last saw her alive on 3-27 1948  
and that death occurred on the date and hour stated above.

4. Sex F. 1 5. Color W. 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased May 1 1872  
(Month) (Day) (Year)

Immediate cause of death Coronary Thrombosis Duration 6 hrs

8. AGE: Years 75 Months 10 Days 28 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

10. Usual occupation Housewife  
11. Industry or business \_\_\_\_\_  
12. Name Austin Green  
13. Birthplace St Charles Co Mo  
(City, town, or county) (State or foreign country)  
14. Maiden name Emma Auld  
15. Birthplace St Charles Co Mo  
(City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Lyster E. Eddens  
(b) Address 31 3rd Barr St Centralia Mo  
17. (a) Burial (b) Date thereof 3/31/48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Wright City Cem  
18. (a) Signature of funeral director Walburg J. A. Co.  
(b) Address Wright City Mo.  
19. (a) 3-30-48 (b) Professor Lawes  
(Date received local registrar) (Registrar's signature)

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 0  
23. Signature Raymond A. Hays (M. D. or other) \_\_\_\_\_  
Address Wright City, Mo. Date signed 3-20-48

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

2000

MOTHER FATHER

RECEIVED  
District Health Officer No. 9,  
District File Number  
Date Filed 4-8-48

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 *Julius J. Nieburg*  
Licensed Embalmer No. *33606*  
P. O. Address *Wright City 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, fact should be so stated above.