

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 2637
196

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. LENGTH OF STAY (In this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital-Max G. Starkloff Memorial		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
		d. STREET ADDRESS 23 - 2204a S 12th Street	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) MARIE	b. (Middle)	c. (Last) EISBACHER	Ja.	6th,	1949

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Oct 17 1870	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 10 HRS. Hours	IF UNDER 1 MIN. Min.
------------------	---------------------------	---	---------------------------------	---------------------------------------	---------------------------	--------------------------	---------------------------	-------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Vienna Austria		12. CITIZEN OF WHAT COUNTRY? U S	
--	--	-----------------------------------	--	---	--	-------------------------------------	--

13a. FATHER'S NAME Joseph Ondrej		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Blazius	
-------------------------------------	--	--------------------------------------	--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Anna Schimse		ADDRESS 2204a S 12th Street	
--	---------------------------------	---	--	--------------------------------	--

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Ca of Cervix</i>			INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			
	DUE TO (b) _____			
	DUE TO (c) _____			
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
------------------------	----------------------------------	--	--	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
--	--	----------------------------

22. I hereby certify that I attended the deceased from 1/4/49, 19 , to 1/6/49, 19 , that I last saw the deceased alive on 1/6/49, 19 , and that death occurred at 8:00A.M., from the causes and on the date stated above.

23a. SIGNATURE <i>M. Allen MD.</i>	(Degree or title)	23b. ADDRESS 1515 Lafayette	23c. DATE SIGNED 1/6/49
---------------------------------------	-------------------	--------------------------------	----------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1/8/49	24c. NAME OF CEMETERY OR CREMATORY Parl Lawn	24d. LOCATION (City, town, or county) (State). St. Louis Mo
---	---------------------	---	--

DATE REC'D BY LOCAL JAN 8 1949	REGISTRAR'S SIGNATURE <i>J. B. Rosater</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Wendell Wood</i>	ADDRESS 1926 Allen
-----------------------------------	---	---	-----------------------

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 _____

me Student Embalmer No. _____

working under my personal supervision.

Signed _____

Benj. C. Duncan
Licensed Embalmer No. *3272*

Signed _____
Student Embalmer

P. O. Address *1924 Allin Dr.*

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.