

FILED NOV 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35089

State File No. 9139

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give town OR TOWN <u>St. Louis</u>)		c. LENGTH OF STAY (In this place) <u>42 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>					
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>6718 Alexander</u>				d. STREET ADDRESS (If rural, give location) <u>6718 Alexander St.</u>					
3. NAME OF DECEASED (Type or Print), a. (First) <u>Selma</u> b. (Middle) <u>M. S.</u> c. (Last) <u>Eberhart</u>			4. DATE OF DEATH (Month) <u>October</u> (Day) <u>24</u> (Year) <u>1949</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>December 6, 1884</u>			
				9. AGE (In years last birthday) <u>64 yrs.</u>		IF UNDER 1 YEAR Days _____ IF UNDER 1 HR. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Collinsville, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Conrad Mueller</u>			13b. MOTHER'S MAIDEN NAME <u>Marie Brase</u>			14. NAME OF HUSBAND OR WIFE <u>Mr. Leonard E. Eberhart</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mr. Leonard E. Eberhart, 6718 Alexander</u>					
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				INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 hrs</u>	
				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Disease (THROMBOSIS)</u>					
				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 checked="" 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) <u>St. Louis Mo.</u>					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Heart</u>					
22. I hereby certify that I attended the deceased from <u>10/21, 1949</u> , to <u>10/24, 1949</u> , that I last saw the deceased alive on <u>10/23, 1949</u> , and that death occurred at <u>1:30 A.M.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Roman Potangand</u>				23b. ADDRESS <u>4520 VIRGINIA AVE.</u>		23c. DATE SIGNED <u>10-24-49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Oct. 26, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St. Trinity Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u>			
DATE REC'D BY LOCAL REG. <u>OCT 25 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Fasalar</u>		25. FUNERAL DIRECTOR'S SIGNATURE (ADDRESS) <u>Beiderwieden F. H. Inc. 1936 St. Louis</u>					

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

Dr. R. J. Stra
4500th Virginia

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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 _____

..... Student Embalmer No. _____
working under my personal supervision.

Student
Student Embalmer

Signed Max L. Waibel

Licensed Embalmer No. 4170

P. O. Address 1936 St Louis 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.