

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34763**
8909

BIRTH NO. _____		REG. DIST. NO. 318		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. COUNTY _____				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Saint Louis		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Saint Louis		2069		
d. FULL NAME OF HOSPITAL OR INSTITUTION Faith Hospital				d. STREET ADDRESS (If rural, give location) 5566 Saint Louis Avenue				
3. NAME OF DECEASED (Type or Print) Casper			a. (First)	b. (Middle)	c. (Last) Eifert	4. DATE OF DEATH (Month) (Day) (Year) Oct. 20th, 1950		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH August 23rd, 1869		9. AGE (In years last birthday) 81	IF UNDER 1 YEAR Months 1 Days 27	IF UNDER 2 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Carpenter			10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Scott County, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME David Eifert			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE Late Bertha Eifert		
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 Mrs. P. L. Scrivner, 4204 Harris Avenue				ADDRESS
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) carcinoma of colon ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) not known DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Perforated bowel at seat of tumor						INTERVAL BETWEEN ONSET AND DEATH ?
19a. DATE OF OPERATION 10-18-50		19b. MAJOR FINDINGS OF OPERATION Carcinoma of Transverse Colon						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <input checked="" type="checkbox"/>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input checked="" type="checkbox"/>		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) 10-19-50 11:30 a.m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 152X				
22. I hereby certify that I attended the deceased from 10-19-1950 , to 10-20-1950 , that I last saw the deceased alive on 10-19-1950 , and that death occurred at 11:30 a.m. , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) H. H. Miller M.D.				23b. ADDRESS 8410 N. Bidway, St. Louis		23c. DATE SIGNED 10-20-50		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Motor		24b. DATE 4/10/22/50		24c. NAME OF CEMETERY OR CREMATORY Lutheran Church Cemetery		24d. LOCATION (City, town, or county) (State) Illmo, Missouri		
DATE REC'D BY LOCAL REG. OCT 20 1950		REGISTRAR'S SIGNATURE J. B. Laster		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Calvin F. Feutz, 4828 Nat'l. Bridge Blvd.				

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

8410 N. Broadview
6 to 7 P.m.

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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

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed *John A. McLean*

Licensed Embalmer No. *4186*

P. O. Address *St. Louis Mo*

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.