

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23676**

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **759**

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

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Andrew	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL, NEAR SAVANNAH	
c. LENGTH OF STAY (In this place) 2 mo		d. STREET ADDRESS (If rural, give location) R.R. #2	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1724 S 12th Street			

3. NAME OF DECEASED (Type or Print) Emma Vadilla Eisinger			4. DATE OF DEATH (Month) (Day) (Year) 7-16-1952		
a. (First)	b. (Middle)		c. (Last)	5. SEX Female	6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH JAN 15-1876	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months 6 Days 1	IF UNDER 24 HRS. Hours Min. 	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife
10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Andrew Co. Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A.		

13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME MARY ELLA Richardson	14. NAME OF HUSBAND OR WIFE James Eisinger
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS Mrs. Marie Eckert 1724 S 12th St Joseph, Mo

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage			5 days
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	ANTECEDENT CAUSES		
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (b) Hypertension		5 years
	DUE TO (c) Sen Arterio-sclerosis		5 years
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) 331X
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 **June 1946**, to **July 16, 1952**, that I last saw the deceased alive on **16 July, 1952**, and that death occurred at **3:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) William B. Kelley MD	23b. ADDRESS Savannah, Mo	23c. DATE SIGNED 7/17/52
24a. BURIAL, CREMATION REMOVAL (Specify) BURIAL	24b. DATE 7-18-52	24c. NAME OF CEMETERY OR CREMATORY SAVANNAH
24d. LOCATION (City, town, or county) (State) SAVANNAH MO	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Carl C. Casper 406 1st St Savannah, Mo	DATE REC'D BY LOCAL REG. July 17, 1952

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 E. E. Breit

Licensed Embalmer No. 2650

P. O. Address SASANNAH MA

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.