

No. 300
10-48

FILED APR 18 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9933**

BIRTH NO. _____ REG. DIST. NO. **245** PRIMARY REG. DIST. NO. **3047** Registrar's No. **28**

1. PLACE OF DEATH a. COUNTY Newton		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Newton	
b. CITY OR TOWN Neosho		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fairview	
d. FULL NAME OF HOSPITAL OR INSTITUTION Sales Memorial Hospital		d. STREET ADDRESS (If rural, give location) _____	

3. NAME OF DECEASED (Type or Print)	a. (First) Ursula	b. (Middle) Winnie Ann	c. (Last) Eiler	4. DATE OF DEATH (Month) (Day) (Year) April 4 1956
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Sept. 6 1874	9. AGE (In years last birthday) 81	10 UNDER 1 YEAR 6 MONTHS 29 DAYS	11 UNDER 1 YEAR None HOURS None MIN.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and State or Foreign Country) McDonald County Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME J. B. Jones	13b. MOTHER'S MAIDEN NAME Mary E. Joy	14. NAME OF HUSBAND OR WIFE James F. Eiler (Deceased)
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mrs Bryan Kruse	ADDRESS Fairview, Mo.
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Massive Cerebral thrombosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) Arteriosclerosis rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 332x			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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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
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22. I hereby certify that I attended the deceased from **4/8**, 19**56**, to **4/4**, 19**56**, that I last saw the deceased alive on **4/4**, 19**56**, and that death occurred at **11:00p** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Randal N. Ochs, M.D.	23b. ADDRESS Whelan Mo	23c. DATE SIGNED 4-5-56
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-8-56	24c. NAME OF CEMETERY OR CREMATORY Macedonia Cem.	24d. LOCATION (City, town, or county) (State) Stella, Missouri
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DATE REC'D BY LOCAL REG. 4-11-56	REGISTRAR'S SIGNATURE Melvin C. Bowman	25. FUNERAL DIRECTOR'S SIGNATURE W. Morris Rife Whelan, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. Newton
District File Number 456-48
Date Filed APR 12 1956

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

W. Marie Rowe

Licensed Embalmer No. 37447

P. O. Address Newton, 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.