

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

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED APR 3 - 1956

State File No. **10666**  
Registrar's No. **2537**

BIRTH NO. **18507-56** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>ST LOUIS</b>		
b. CITY (If outside corporate limits, write RURAL and give township) <b>ST LOUIS</b>		c. LENGTH OF STAY (In this place) <b>1 DAY</b>	c. CITY OR TOWN <b>AFTON</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST ANTHONY HOSP.</b>			e. STREET ADDRESS (If rural, give location) <b>4756 STONE AV.</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>CHRISTINE</b>		b. (Middle) <b>YANE</b>	c. (Last) <b>EILERMANN</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>MAR - 11 - 1956</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>BABY</b>	8. DATE OF BIRTH <b>MAR - 10 - 1956</b>	9. AGE (In years last birthday) <b>0</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>1</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>ST LOUIS MO</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>BILLIE EILERMANN</b>		13b. MOTHER'S MAIDEN NAME <b>JOHANNA CHOTT</b>	14. NAME OF HUSBAND OR WIFE <b>NONE</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT'S SIGNATURE OR NAME <b>MR BILLIE EILERMANN</b>		ADDRESS <b>4756 STONE AV. AFTON MO</b>	
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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>anoxia due to intracranial</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>hemorrhage -</b> DUE TO (c) <b>prematurity 28 1/2 wks. gestation.</b>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Breech delivery. wt. 2 1/6 lbs.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>at birth.</b>
19a. DATE OF OPERATION <b>—</b>	19b. MAJOR FINDINGS OF OPERATION <b>760.5</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>none</b>	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 <b>3/10</b> , 19 <b>56</b> , to <b>3/11</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>3/10</b> , 19 <b>56</b> , and that death occurred at <b>2:00 a</b> m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <b>Wm. J. Wotawa M.D.</b>		23b. ADDRESS <b>3804 Wilmington Ave</b>		23c. DATE SIGNED <b>3/11/56.</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>MAR - 12 - 1956</b>	24c. NAME OF CEMETERY OR CREMATORY <b>PARK LAWN CEM.</b>	24d. LOCATION (City, town, or county) (State) <b>LEMAV. MO.</b>		
DATE REC'D BY LOCAL REG. <b>MAR 12 1956</b>	REGISTRAR'S SIGNATURE <b>J. Euel Smith M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Fey FUNERAL HOME</b>	ADDRESS <b>MENNVILLE, MO</b>		

m. J. B. (Licensed Embalmer's Statement on Reverse Side)

**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.....  
Signature of Student Embalmer



Signed.....  
*No: Embalm.*  
*Paul J. J.*

Licensed Embalmer No.....

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.