

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 8 1956

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 904

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		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 township) OR TOWN <u>Normandy</u>	c. LENGTH OF STAY (in this place) <u>3 days</u>	c. CITY OR TOWN <u>St Louis 20</u>	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 <u>Normandy Osteopathic Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>6017 Lucille</u>	

3. NAME OF DECEASED (Type or Print) <u>WILLIAM</u>	a. (First)	b. (Middle)	c. (Last) <u>EYRE</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>4-2-56</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>M</u>	8. DATE OF BIRTH <u>6-13-1880</u>	9. AGE (In years last birthday) <u>75</u>	IF UNDER 1 YEAR Months _____	IF UNDER 1 YEAR Days _____	IF UNDER 1 Hrs. Hours _____	IF UNDER 1 Min. Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>City of St. Louis Park Dept.</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>England</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>William Eyre</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Rebecca Eyre</u>
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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>Unknown</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Wm. C. Eyre, 6017 Lucille Ave.</u>	ADDRESS _____
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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, asthenia, 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) <u>Cerebrumy Embolism</u>		<u>5 min</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Auricular Fibrillation</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>		<u>2 hour</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Massive Anasarca</u>		<u>2 week</u>	

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input checked="" 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) (Min.) _____	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 3-30, 1956, to 4-2, 1956, that I last saw the deceased alive on _____, 1956, and that death occurred at 11:11a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Robert W. Shelby MD</u>	23b. ADDRESS <u>19179. Hanky Rd</u>	23c. DATE SIGNED <u>4-2-56</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	24b. DATE <u>4/5/56.</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Crematory</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>4-3-56</u>	REGISTRAR'S SIGNATURE <u>Herbert R. Dougl...</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>CALVIN F. FEUTZ</u>	ADDRESS <u>FUNERAL HOME, INC. 4828 Natural Bridge Blvd. St. Louis 15, Mo.</u>
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(Licensed Funeral Director's Statement on Reverse Side)

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

STATE OF MISSOURI
DEPARTMENT OF HEALTH

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..... *Ralph C. Zindler*

Licensed Embalmer No. *427*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.