

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **29408**  
Registrar's No. **7980**

FILED SEP 4 1957

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1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>7980</b>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo.</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) <b>19-dys.</b>		c. CITY OR TOWN <b>St. Louis</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>26 St. Louis Chronic Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>309 W. Stein</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Emma</b>			b. (Middle) _____			c. (Last) <b>Eigelberger</b>	
4. DATE OF DEATH <b>8-25-57</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOW</b>	
8. DATE OF BIRTH <b>2-17-1880</b>		9. AGE (In years last birthday) <b>77</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>			11. BIRTHPLACE (City and State or Foreign Country) <b>Mehlville, Mo.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13a. FATHER'S NAME <b>Joseph Sagez</b>		13b. MOTHER'S MAIDEN NAME <b>Josephine LeBlanc</b>	
14. NAME OF HUSBAND OR WIFE <b>Otto Eigelberger</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>May Schutt, Sappington, Mo</b>				ADDRESS <b>Sappington, 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, ashenia, etc.; it means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION - DIRECTLY LEADING TO DEATH* (a) <b>Unknown type Metastatic Carcinoma</b> INTERVAL BETWEEN ONSET AND DEATH <b>18 days.</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Unknown type C.A. of Carcinoma</b> <b>18 days.</b> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <b>Basal Cell C.A. of Nose</b> Conditions contributing to the death but not related to the disease or condition causing death. <b>Multiple Decubiti</b> <b>18 days.</b>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>19.1x</b>		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)			
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?			
22. I hereby certify that I attended the deceased from <b>8-7-</b> 19 <b>57</b> , to <b>8-25-</b> 19 <b>57</b> , that I last saw the deceased alive on <b>8-25-</b> 19 <b>57</b> , and that death occurred at <b>5:35pm.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>John W. Beckheim, M.D.</b>				23b. ADDRESS <b>5820 Arsenal</b>		23c. DATE SIGNED <b>8/26/57</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <b>8-28-57</b>		24c. NAME OF CEMETERY OR CREMATORY <b>LAKELWOOD PARK</b>		24d. LOCATION (City, town, or county) (State) <b>ST. LOUIS, MO</b>	
DATE REC'D BY LOCAL REG. <b>AUG 26 57</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>FENDLER UND. 7420 NICHIGAN</b>		ADDRESS	

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

**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 *W. G. Peterson* .....

Licensed Embalmer No. *3767* .....

P. O. Address *7420 Mich* .....

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.