

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

21-58

58-004296

STATE FILE NUMBER

FILED FEB 24 1958

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 57

1. PLACE OF DEATH a. COUNTY <b>Adair</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Adair</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kirksville</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Kirksville</b> 20/3 Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>316-N-BOUNDRY</b>		d. STREET ADDRESS (If outside, give location) <b>316-N-BOUNDRY</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lyle</b> Middle <b>MARTIN</b> Last <b>Eiler</b>		4. DATE OF DEATH <b>Jan. 25, 1958</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 5, 1958</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (City and state or country) <b>Kirksville, Mo</b>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Carl Eiler</b>		14. MOTHER'S MAIDEN NAME <b>Lizzie Glaspie</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT Address <b>Carl Eiler, 316-N-BOUNDRY, Kirksville</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>medullary failure</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>cerebral anoxia</b> DUE TO (c) <b>congenital heart disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b> <b>20 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>7545</b>	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from _____ to <b>1-25-58</b> and last saw <sup>him</sup> alive on <b>1-25-58</b> Death occurred at <b>5:30 am</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>R. B. Maddox</b> (Degree or title) <b>DO 2</b>		22b. ADDRESS <b>Kirksville Osteopath</b> DATE SIGNED <b>1-29-58</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>1-27-1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Llewellyn Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Kirksville Mo</b>
24. FUNERAL DIRECTOR <b>Davis &amp; Davis, Kirksville, Mo</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>2-20-58</b>	26. REGISTRAR'S SIGNATURE <b>Doris W. Padoff</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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 *Robert B. Davis*.....

Licensed Embalmer No. *421*.....

P. O. Address *Kirkland*.....

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.