

Health,  
Welfare  
Public  
Service

XC-2046 98 16  
Reg. 120 532

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-023713  
STATE FILE NUMBER

FILED JUL 3 1959 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1720

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>ILLINOIS</b> b. COUNTY <b>MADISON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>JEFFERSON BARRACKS, MO.</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>GRANITE CITY</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VET. ADM. HOSPITAL</b>		Length of stay in lb <b>465 DAYS</b>	d. STREET ADDRESS (If outside, give location) <b>2138 STATE STREET</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>ANDREW FRANCIS EILER</b>			4. DATE OF DEATH Month Day Year <b>6-26-59</b>		
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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>5-26-1889</b>	9. AGE (In years last birthday) <b>70</b> IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STORE OWNER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>PAINT &amp; WALLPAPER</b>	11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MO.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>ANDREW F. EILER</b>	13b. MOTHER'S MAIDEN NAME <b>MARY HOFFMAN</b>	14. NAME OF HUSBAND OR WIFE -----
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give way or dates of service) <b>YES WW-I</b>	16. SOCIAL SECURITY NO. <b>VA HOSP. RECORDS, JEFFERSON BARRACKS, MO.</b>	17. INFORMANT Address <b>VA HOSP. RECORDS, JEFFERSON BARRACKS, MO.</b>
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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>CORONARY THROMBOSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>30 Min.</b>
DUE TO (b) <b>ARTERIOSCLEROSIS</b>		
DUE TO (c) <b>ARTERIOSCLEROSIS, GENERAL AND CEREBRAL</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>ARTERIOSCLEROSIS, GENERAL AND CEREBRAL</b>		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>4201</b>
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20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>VA</b>	20f. CITY, TOWN, OR LOCATION <b>JEFFERSON BARRACKS, MO.</b>	COUNTY <b>JEFFERSON</b>	STATE <b>MO.</b>
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21. I attended the deceased from <b>3-18-58</b> to <b>6-26-59</b> and I was present at the death on the date stated above; and to the best of my knowledge, from the causes stated. Death occurred at <b>2:15 p.m.</b>	22a. SIGNATURE <b>W. OPLER, Director Professional Serv.</b>	22b. ADDRESS <b>VA HOSP. JEFFERSON BARRACKS, MO.</b>	22c. DATE SIGNED <b>6-26-59</b>
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23a. BURIAL, CREMATION OR REMOVAL (Specify) <b>Calvary</b>	23b. DATE <b>6-29-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>	23d. LOCATION (City, town, or county) (State) <b>Elevadoale Ill, Ill</b>
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24. FUNERAL DIRECTOR <b>Ripley Funeral Home</b>	ADDRESS <b>Gray to 6:26-59</b>	25. DATE RECD. BY LOCAL REG. <b>6-26-59</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy, MD</b>
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(Licensed Embroider and Sealant on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

AUG 14 1961

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 Not Embalmed, Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed Henry J. Pijer, Jr.  
Licensed Embalmer No. ....  
P. O. Address .....

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.