

FEDERAL BUREAU OF INVESTIGATION  
 U.S. DEPARTMENT OF JUSTICE  
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**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-041788**

**FILED VS DEC 11 1959**

**211024**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

UNDECEASED

<b>1. PLACE OF DEATH</b> a. COUNTY _____ b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b> Length of stay in 1b <b>43 years</b> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Luke's Hospital</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____ c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (if outside, give location) <b>6427 Devonshire</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>ALICE</b> Middle <b>ANNA</b> Last <b>EIGEL</b>			<b>4. DATE OF DEATH</b> Month <b>November</b> Day <b>26,</b> Year <b>1959</b>				
<b>5. SEX</b> Female	<b>6. COLOR OR RACE</b> White	<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> 10/28/16	<b>9. AGE</b> (last birthday) <b>43 yrs.</b>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR</b> Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) At Home		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (City and state or country) St. Louis, Missouri	<b>12. CITIZEN OF WHAT COUNTRY</b> USA		
<b>13a. FATHER'S NAME</b> Max J. Karch		<b>13b. MOTHER'S MAIDEN NAME</b> Laura Schroeter		<b>14. NAME OF HUSBAND OR WIFE</b> John A. Eigel			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) No.		<b>16. SOCIAL SECURITY NO.</b> None	<b>17. INFORMANT</b> Address Mr. John A. Eigel, 6427 Devonshire				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute cardiac dilatation - metastasis C, pulm ven</i> DUE TO (b) <i>extending to atrium (b) malignant mixed tumor</i> DUE TO (c) <i>metastases both lungs (c) malignant mixed tumor left atrium</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 3 yrs 8 mos		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. 1602 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART III of item 18.) 1602					
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>	<b>STATE</b>		
<b>21. I attended the deceased from</b> <i>April 1955</i> to _____ and last saw her <i>11/26/59</i> alive on _____ Death occurred at _____ <i>10:35 P.</i> m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> <i>Louis H. Jarstad</i> (Doctor or title)			<b>22b. ADDRESS</b> <i>3120 Washington</i> <i>3720 Washington</i>		<b>22c. DATE SIGNED</b> <i>11/28/59</i>		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> Burial		<b>23b. DATE</b> Nov. 30, 1959	<b>23c. NAME OF CEMETERY OR CREMATORY</b> Concordia Cemetery		<b>23d. LOCATION</b> (City, town, or county) (State) St. Louis, Missouri		
<b>24. FUNERAL DIRECTOR</b> ADDRESS Beiderwieden F.H.Inc. 1936 St. Louis			<b>25. DATE RECD. BY LOCAL REG.</b> NOV 30 1959	<b>26. REGISTRAR'S SIGNATURE</b> <i>Paul Smith, M.D.</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NS DEC 1 1958

**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 Homer W. Fri

Licensed Embalmer No. 3882

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.