

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. JAN 13 1961

318

1003

12625-60-047454

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Alexian Brothers Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>736 Bittner St.,</u>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>HEYK a/k/a HENRY</u> Middle <u>W.</u> Last <u>EILERS</u>			4. DATE OF DEATH Month <u>December</u> Day <u>30th</u> Year <u>1960</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/1/90</u>	9. AGE (last birthday) <u>70</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Gillispie, Ill</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>? Eilers</u>		13b. MOTHER'S MAIDEN NAME <u>Tin a Folkere</u>		14. NAME OF HUSBAND OR WIFE <u>Wilma Eilers</u>	

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>489-10-2891</u>	17. INFORMANT <u>Wilma Eilers, 736 Bittner St.,</u>	Address
---	---	--	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>? 1/2 year</u>
DUE TO (b) <u>metastasis</u>		
DUE TO (c) <u>Carcinoma of bladder</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>181.0</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
---	---	--

20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
---	------------------

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
--	--	------------------------------	--------	-------

21. I attended the deceased from June 15-53 to 12-30-60 and last saw her/him alive on Dec 30-60
Death occurred at Dec 30-60 on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Stephen M. Tapper MD</u>	(Degree or title)	22b. ADDRESS <u>3720 Washington</u>	22c. DATE SIGNED <u>Dec 31-60</u>
---	-------------------	--	--------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>1/3/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Bethlehem Cemetery</u>	23d. LOCATION (City, town, or county) <u>St. Louis Co., Mo.</u>	(State)
---	----------------------------	---	--	---------

24. FUNERAL DIRECTOR <u>DIEDRICH FUNERAL HOME, 8319 Hallsferry</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>DEC 31 1960</u>	26. REGISTRAR'S SIGNATURE <u>Ed Smith M.D.</u>
---	---------	--	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
 or by _____, Student Embalmer No. _____
 working under my personal supervision.
 Student _____
 Signature of Student Embalmer _____

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
 or by _____, Student Embalmer No. _____
 working under my personal supervision.

Student _____
 Signature of Student Embalmer _____

Signed Harry E. Monroe
 Licensed Embalmer, No. 4493
 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.