

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

28543

State File No. 702

Registration District No. 318

Primary Registration District No. 2001

Registrar's No.

1. PLACE OF DEATH:

(a) County GREENE  
(b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 2263 N. Ramsey 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days) 2 III

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene  
(c) City or town Springfield  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2263 N. Ramsey  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 24  
year 1940 hour 6:45 minute \_\_\_\_\_ P. M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to Aug. 24, 1940  
that I last saw her alive on Aug. 24, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death: Cardiac decompensation 10 days  
the degenerative myocarditis  
chronic heart disease  
Duration \_\_\_\_\_

Other conditions (Includes pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_  
Signature Arthur D. Knab (M. D. or other) MD  
Address 450 W. E. Cecil Date signed 8/26/40

3. (a) PRINT FULL NAME Mrs. Mary Eagleburger

8. (b) If veteran, name war None (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife J. S. Eagleburger 6. (c) Age of husband or wife if alive See years

7. Birth date of deceased February 23, 1859  
(Month) (Day) (Year)

8. AGE: Years 81 Months 6 Days 1 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Maytown, Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation Dr. Housewife

11. Industry or business Dr. Home

12. Name Mathias Noel

13. Birthplace Unknown France  
(City, town, or county) (State or foreign country)

14. Maiden name Anna Frederick

15. Birthplace Unknown Germany  
(City, town, or county) (State or foreign country)

16. (a) Informant George Eagleburger

(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof 8-26-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cemetery

18. (a) Signature of funeral director Alma Bohmer

(b) Address Springfield, Mo.

19. (a) Aug. 26, 1940 (b) W. E. Handley, MD  
(Date received local registrar) (Registrar's signature)

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

9

**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.....

C. C. George....., Registered Apprentice No. ....  
working under my personal supervision.

Signed Lewis G. Schaff.....

Licensed Embalmer No. 3802.....

P. O. Address Springfield Mo......

**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 this body is not embalmed, above space should be left blank.**