

**FILED MAR 14 1945**  
**318**

Registration District No. \_\_\_\_\_ Primary Registration District No. **1003**

Registrar's No. **2009**

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town ST LOUIS  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
2533 BACON ST 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 mos  
(Specify whether \_\_\_\_\_)  
In this community 3 mos  
years, months or days

3. (a) PRINT FULL NAME GARY MARTIN EYERDING

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased July 13 1944  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
0 7 18 hr. min.

9. Birthplace ST LOUIS MO  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name WILLIAM EYERDING  
13. Birthplace BALDWIN ILL  
(City, town, or county) (State or foreign country)  
14. Maiden name ROSA PIEL  
15. Birthplace RED BUD ILL  
(City, town, or county) (State or foreign country)

16. (a) Informant WILLIAM EYERDING  
(b) Address 2533 BACON ST

17. (a) REMOVAL (b) Date thereof 3-1-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation RED BUD ILL

18. (a) Signature of funeral director KOCH FUNERAL HOME  
(b) Address RED BUD ILL

19. (a) MAR 1 1945 (b) J. T. [Signature]  
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 000 17  
(c) City or town ST LOUIS 9 11  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2533 BACON ST  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country ( )

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 1ST  
year 1945 hour 5 minute 45 A.M.

21. I hereby certify that I attended the deceased from Feb. 27, 1945 to Mar. 1, 1945  
that I last saw him alive on Feb. 27, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Bronchial Pneumonia  
Primary

Due to \_\_\_\_\_

Due to 107

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

(c) 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)  
(c) Means of injury 0

23. Signature C. E. Williamson (M. D. or other) \_\_\_\_\_  
Address 6336 Clayton Road Date signed 3/1/45

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

**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed John Ketter  
Licensed Embalmer No. 3880  
P. O. Address St Louis 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, fact should be so stated above.**