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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 16 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

24882

State File No.

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 1458

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

1. PLACE OF DEATH:
(a) County St Louis.
(b) City or town Koch Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Koch Hospital. D
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 16 mo. (Specify whether
In this community all her life. years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 00 17
(c) City or town St Louis. Missouri 9
(If outside city or town limits, write "RURAL")
(d) Street No. 4374 Fairfax. (If rural give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME HAZEL M. EULINBERG
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex O+3
5. Color or race NEGRO
6. (a) Single, widowed, married, divorced 3
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 11 (Month) 11 (Day) 1903 (Year)

8. AGE: Years 42 Months 8 Days 26 If less than one day hr. min.

9. Birthplace St Louis (City, town, or county) Missouri D (State or foreign country)
10. Usual occupation laundress
11. Industry or business --
FATHER
12. Name Armstead Eulinberg
13. Birthplace Jackson (City, town, or county) Missouri D (State or foreign country)
MOTHER
14. Maiden name Christina Bryant
15. Birthplace (2) (City, town, or county) Missouri (State or foreign country)
16. (a) Informant Robert Koch Hosp. record
(b) Address Koch. Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-11-46 (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park
18. (a) Signature of funeral director Chas. J. Gates
(b) Address 4107 Finney Ave.
19. (a) 7-11-46 (Date received local registrar) (b) E.G. McGavran MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 7. year 1946 hour 6 minute 40 A.M.
21. I hereby certify that I attended the deceased from 3-27-45, 19, to 7-7, 1946
that I last saw her alive on July - 7, 1946
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pulmonary tuberculosis	2½ years
Due to 13d	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations thoracoplasty left.
Of autopsy Pulmonary TBC.

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature Samuel J. Kunzdeck (M.D. ~~or other~~)
Address Koch Hosp. Koch, Mo Date signed 7/7/46

(Licensed Embalmer's Statement on Reverse Side)

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

Thomas J. Gates, Registered Apprentice No.

working under my personal supervision.

Signed

Licensed Embalmer No. 4259

P. O. Address 4107 Finney Avenue

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.