

FILED JUN 3 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15478

BIRTH NO. _____ REG. DIST. NO. ~~119~~ PRIMARY REG. DIST. NO. 4191 Registrar's No. 15

1. PLACE OF DEATH a. COUNTY GASCONADE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI COUNTY GASCONADE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN GASCONADE		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN GASCONADE	
c. LENGTH OF STAY (In this place) 86 YRS		d. STREET ADDRESS (If rural, give location) 0320	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. FULL NAME OF HOSPITAL OR INSTITUTION	

3. NAME OF DECEASED (Type or Print)	a. (First) William	b. (Middle) V	c. (Last) EGGENBERG, SR.	4. DATE OF DEATH (Month) (Day) (Year) MAY 21 1954
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH DEC. 12, 1867	9. AGE (In years last birthday) 86	IF UNDER 1 YEAR Months Days	IF UNDER 4 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	10b. KIND OF BUSINESS OR INDUSTRY FARMING	11. BIRTHPLACE (State or foreign country) MISSOURI	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME UNKNOWN	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE MINNIE EGGENBERG
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME ADDRESS MRS. MINNIE EGGENBERG, GASCONADE
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hepatic pneumonia		48 hrs.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Circulatory failure DUE TO (c) Cerebral vascular accident		1 wk. 6/2/53
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **6/2/53** 19___, to **5/21/54**, 19___, that I last saw the deceased alive on **5/19/54**, 19___, and that death occurred at **1:30 A.** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) L. E. Jeter, M.D.	23b. ADDRESS Hermann, Mo.	23c. DATE SIGNED 5/22/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE MAY 23, 1954	24c. NAME OF CEMETERY OR CREMATORY Good Hope Cemetery	24d. LOCATION (City, town, or county) (State) MORRISON, MO.
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DATE REC'D BY LOCAL REG. May 23, 1954	REGISTRAR'S SIGNATURE Delma Gerken	FUNERAL DIRECTOR'S SIGNATURE James Hermann, Mo.	ADDRESS 492 S. NUGOST
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WRITE PLAINLY—USING 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.....

.....
working under my personal supervision.

Signed.....
Student Embalmer

Student Embalmer No.....

Signed.....

Licensed Embalmer No. 3160

P. O. Address. Hermann, 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.