

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-041780**

RECEIVED

FILED 19 DEC 7 1959

Primary Registration District No.

Registrar's No. **2 9853**

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b> Length of stay in 1b <b>11 days</b> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Alexian Bros. Hospital</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY c. CITY OR TOWN <b>Lemay</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>518 Buckley</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Wenzel</b> Middle <b>M.</b> Last <b>Eberhardt</b>			<b>4. DATE OF DEATH</b> Month <b>October</b> Day <b>27</b> Year <b>1959</b>				
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>7/8/1919</b>	<b>9. AGE</b> (last birthday) <b>40</b> IF UNDER 1 YEAR Months Days Hours Min.	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Chemist</b>		
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Busch Brewery</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>St. Louis, Missouri</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>			
<b>13a. FATHER'S NAME</b> <b>Wenzel Eberhardt</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Natalie Stankovics</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Maxine Leak Eberhardt</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>	<b>17. INFORMANT</b> Address <b>Maxine Eberhardt 518 Buckley Lemay, Mo.</b>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hodgkins Disease</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <b>201x</b>					INTERVAL BETWEEN ONSET AND DEATH <b>32 yrs.</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				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			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>					
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b> <b>STATE</b>			
<b>21. I attended the deceased from</b> <b>June 1956</b> , to <b>death</b> and last saw her alive on <b>27 October 1959</b> Death occurred at <b>October 27 10 A.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> <i>John G. Kellett M.D.</i> <b>John G. Kellett M.D.</b>			<b>22b. ADDRESS</b> <b>2623 Telegraph Road. Lemay Mo.</b>		<b>22c. DATE SIGNED</b> <b>10/27/59</b>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE</b> <b>Oct. 30, 1959</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Galvary Cemetery</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>St. Louis, Mo.</b>			
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>C. Hoffmeister Mortuaries</b> <b>7814 So. Broadway St. Louis, Mo.</b>			<b>25. DATE RECD. BY LOCAL REG.</b> <b>OCT 27 1959</b>	<b>26. REGISTRAR'S SIGNATURE</b> <i>Earl Smith M.D.</i> <b>Earl Smith M.D.</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

M.P.

**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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Linus C. Hoffman*

Licensed Embalmer No. 3871

P. O. Address 7814 S. B.

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.