

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-018191

STATE FILE NUMBER

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 7624

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAY 21 1962		1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY BUTLER		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF		a. STATE MO. b. COUNTY DUNKLIN	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DOCTOR'S HOSPITAL		Length of stay in 1b 18 Days		c. CITY OR TOWN CAMPBELL Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. STREET ADDRESS ROUTE # 1		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN A. EBERHARD			4. DATE OF DEATH APRIL 28, 1962		
5. SEX MALE		6. COLOR OR RACE WHITE		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	
8. DATE OF BIRTH AUG. 20, 1890		9. AGE (last birthday) 71 Yrs		IF UNDER 1 YEAR IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (City and state or country) ST. JOHN, INDIANA	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME ALOIS EBERHARD		13b. MOTHER'S MAIDEN NAME ANTOINETTE FELLER	
14. NAME OF HUSBAND OR WIFE JOSEPHINE ENGELIN		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. [REDACTED]	
17. INFORMANT Josephine EBERHARD, CAMPBELL, MO.		18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Renal failure secondary to pyelonephritis		INTERVAL BETWEEN ONSET AND DEATH 4 days	
DUE TO (b) Prostate resection		DUE TO (c) Benign hypertrophy of prostate		12 days	
DUE TO (c) Surgical shock		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Resection of prostate 12 days before death		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	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		20g. COUNTY		20h. STATE	
21. I attended the deceased from 4-10-62 to 4-28-62 and last saw him alive on 4-28-62					
Death occurred at 11:30 am on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE T.E. Ruff m.d. (Degree or title)		22b. ADDRESS 623 Pine Poplar Bluff mo		22c. DATE SIGNED 5-15-62	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 4-30-1962		23c. NAME OF CEMETERY OR CREMATORY ST. JOSEPH, CEMETERY	
23d. LOCATION (City, town, or county) EVANSVILLE, INDIANA.		23e. (State)		23f. (State)	
24. FUNERAL DIRECTOR DAY & KNIGHT, F.H. MALDEN, MO.		25. DATE RECD. BY LOCAL REG. 5/18/1962		26. REGISTRAR'S SIGNATURE Thelma Graham	

VS 300	Rev. 4/59	DATE AMENDED	6/12/62	6/12/62	6/12/62
10128	20352	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	SHOULD READ	BY AFFIDAVIT OF
3	4 0	7 1	8 1	9 6/10X	10
11	12 2-0	13 1-0	18a	18b	18c
			acute renal failure	lower nephron nephrosis	prostate surgical shock
			pyelonephritis	prostate resection	benign hypertrophy of prostate
					attending physician

USE BLACK INK OR TYPEWRITER RIBBON

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

Raymond L. Duffie

Licensed Embalmer No. 4798

P. O. Address Berme, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.