

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-036103

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **9112**

STATE FILE NUMBER

FILED SEP 28 1962

VS 300  
Rev. 4/59

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STATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE 'BLACK INK  
OR  
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		c. CITY OR TOWN	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
5. SEX		6. COLOR OR RACE	
7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		14. NAME OF HUSBAND OR WIFE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral vascular accident with brain damage 6 days</i> DUE TO (b) <i>Stenosed arteries</i> DUE TO (c) <i>331+</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>15 years</i>
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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	
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		COUNTY STATE	
21. I attended the deceased from <i>Sept. 1947</i> to <i>Sept. 27-1962</i> and last saw <sup>her</sup> alive on <i>Sept. 19, 1962</i> Death occurred at <i>7:30 A.</i> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title)		22b. ADDRESS	
22c. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR		25. DATE RECD. BY LOCAL REG.	
26. REGISTRAR'S SIGNATURE			

1. **PL. OF DEATH**: a. COUNTY: *St. Louis*  
 2. **USUAL RES.**: a. STATE: *Mo*, b. COUNTY: *St. Louis*  
 3. **NAME OF DECEASED**: *Maria Eberhardt*  
 4. **DATE OF DEATH**: *Sept 19-1962*  
 5. **SEX**: *F*  
 6. **COLOR OR RACE**: *W*  
 7. **MARRIED**:  Widowed  
 8. **DATE OF BIRTH**: *8-15-1879*  
 9. **AGE**: *83*  
 10. **USUAL OCCUPATION**: *Housework*  
 10b. **KIND OF BUSINESS OR INDUSTRY**: *Own home*  
 11. **BIRTHPLACE**: *Austria*  
 12. **CITIZEN OF WHAT COUNTRY**: *U.S.A.*  
 13a. **FATHER'S NAME**: *Deutsch*  
 13b. **MOTHER'S MAIDEN NAME**: *Unger*  
 14. **NAME OF HUSBAND OR WIFE**: *Deceased*  
 15. **ARMED FORCES**: *No*  
 16. **SOCIAL SECURITY NO.**: *None*  
 17. **INFORMANT**: *Joseph Eberhardt - 700 Bittner*  
 18. **CAUSE OF DEATH**: *Cerebral vascular accident with brain damage 6 days*  
 19. **AUTOPSY**:  NO  
 20a. **ACCIDENT SUICIDE HOMICIDE**:     
 20b. **HOW INJURY OCCURRED**: *331+*  
 20c. **TIME OF INJURY**:  
 20d. **INJURY OCCURRED WHILE AT WORK**:   
 20e. **PLACE OF INJURY**:  
 20f. **CITY, TOWN, OR LOCATION**: *St. Louis*  
 20g. **COUNTY STATE**: *Mo*  
 21. **ATTENDED DECEASED**: *Sept. 1947 to Sept. 27-1962*  
 22a. **SIGNATURE**: *John R Morris M.D.*  
 22b. **ADDRESS**: *8124 1/2 E. Broadway*  
 22c. **DATE SIGNED**: *Sept 20-62*  
 23a. **BURIAL, CREMATION, REMOVAL**: *Burial*  
 23b. **DATE**: *9-22-1962*  
 23c. **NAME OF CEMETERY OR CREMATORY**: *Calvary Cemetery*  
 23d. **LOCATION**: *St. Louis Mo*  
 24. **FUNERAL DIRECTOR**: *Edgar Koch + Son - 3516 N. 14th*  
 25. **DATE RECD. BY LOCAL REG.**: *SEP 21 1962*  
 26. **REGISTRAR'S SIGNATURE**: *Roald Smith M.D.*

**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 Tom M. Sizemore

Licensed Embalmer No. 4343

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.