

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-045232

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3461

DO NOT WRITE ON THIS STUB

AMENDED

FILED DEC 3 1962

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS b. COUNTY MADISON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN JEFFERSON BARRACKS, MO.		c. CITY OR TOWN COLLINSVILLE	
Length of stay in 1b 5 DAYS		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS (If outside, give location) 404 SOUTH STREET	
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First HERMAN Middle G. Last EBERHART			4. DATE OF DEATH Month NOVEMBER Day 26 Year 1962		
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-4-89	9. AGE (last birthday) 73	IF UNDER 1 YEAR Months Days Hours Min.
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 (City and state or country) CASEVILLE, ILL.		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME GOTTLIEB EBERHART		13b. MOTHER'S MAIDEN NAME ELIZABETH AMBROSIOUS		14. NAME OF HUSBAND OR WIFE -----	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-I		16. SOCIAL SECURITY NO. None	17. INFORMANT Theodore Eberhart, 404 South St., Collinsville, Ill.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MARKED BRONCHOPNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH 1 week
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) RIGHT LOWER LOBE ORGANIZING PNEUMONIA, BILATERAL APICAL CAVITARY TUBERCLE 1.5 CM SIZE PULMONARY EMPHYSEMA, FRACTURE RIGHT FEMUR WITH VALGUS DEFORMITY, CHOLELITHIASIS		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
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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 _____ a.m. _____ p.m. 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.) VA	20f. CITY, TOWN, OR LOCATION VA	COUNTY _____ STATE _____
21. attended the deceased from 11-21-62 to 11-26-62 and last saw him alive on _____		Death occurred at 1:50 PM on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE (Registrar title) <i>John Mueller</i>	22b. ADDRESS M.D. VA HOSP. JEFF. BRKS. MO.	22c. DATE SIGNED 11-26-62
23a. BURIAL, CREMATION REMOVAL (Specify) REMOVAL	23b. DATE 11/29/62	23c. NAME OF CEMETERY OR CREMATORY Holy Cross Lutheran
23d. LOCATION (City, town, or county) Collinsville, Illinois		(State) _____

24. FUNERAL DIRECTOR Herr Funeral Home, Collinsville, Ill.	ADDRESS _____	25. DATE RECD. BY LOCAL REG. 11-27-62	26. REGISTRAR'S SIGNATURE <i>John Mueller M.D.</i>
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 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 SHOULD READ
 BY AFFIDAVIT OF
 DOCUMENT
 MEDICAL CERTIFICATION
 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 *Travis H. J.*

Licensed Embalmer No. 3577

P. O. Address Collinsville, Ill

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.