LOCAL REGISTRAR'S RECORD DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. 781 File No. 31002

or

Village ..... Primary Registration District No. 1003 Registered No. 8951

or

City St Louis (NO. 1309 Wyoming St.; 10 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Dorothy Marie Eckrich

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) S.

6 DATE OF BIRTH Nov (Month) 18 (Day), 1917 (Year)

7 AGE ..... yrs. 10 mos. 8 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work —
(b) General nature of industry business, or establishment in which employed (or employer) —

9 BIRTHPLACE (City or town, State or foreign country) St. Louis

PARENTS

10 NAME OF FATHER John M Eckrich

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) St Louis

12 MAIDEN NAME OF MOTHER Olga Achtermann

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Denver Colo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John M Eckrich

(Address) 1309 Wyoming St

15 Filed SEP 27 1918, 191 Max C Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept (Month) 26 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from September 22d, 1918, to September 25th, 1918, that I last saw her alive on September 25th, 1918, and that death occurred, on the date stated above, at 1 A.m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-enteritis

1193

104

(Duration) — yrs. — mos. four ds.

8 CONTRIBUTORY (Secondary) —

— (Duration) — yrs. — mos. — ds.

(Signed) Lawrence Thumser M. D.

Sept. 26th, 1918 (Address) 1808 Victor St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL SS. Peter Paul

DATE OF BURIAL Sept 28, 1918

20 UNDERTAKER Wacker Helderle

ADDRESS 2331 S Bdwy

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... 1.....
(Month) (Day) (Year)

7 AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

....., 191.....
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from

....., 191....., to....., 191.....

that I last saw h.....alive on....., 191.....,

and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed).....M. D.

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191.....
20 UNDERTAKER	**ADDRESS**