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

Do not use this space.

20122

1. PLACE OF DEATH

County..... Registration District No. 791 File No. .....

Township..... Primary Registration District No. 1003 Registered No. 5892

City St. Louis (No. City Hospital #1 (Enroute) St. ..... Ward)

2. FULL NAME Axel M. Eckebald

(a) Residence. No. 1231 Olive St. St., 25 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Widower

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Unknown

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Unknown

7. AGE: Alt — YEARS: 40 — MONTHS: 1 — DAYS: — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Jeweler
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Sweden

PARENTS

10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): — —
12. MAIDEN NAME OF MOTHER: — —
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): — —

14. INFORMANT: H. W. Fath
(Address) Deputy Coroner

15. FILED 27 1927 19 Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 6/3 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 7-15 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Haemorrhage of Lungs
Pulmonary Tuberculosis
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): N. M. Q.
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?.....
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed) H. W. Fath, M. D.
6/27, 1927 (Address) Deputy Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Missouri Crematory
DATE OF BURIAL: 6/27 1927

20. UNDERTAKER: Southern U & L Co
ADDRESS: 7315 S Bidwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.