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

Do not use this space.

34999

1. PLACE OF DEATH
County St. Louis
Township
City (No. 773 Lemay Ferry Rd. St. Ward)
Registration District No.
Primary Registration District No. 0225
File No.
Registered No. 350

2. FULL NAME Anna M. Eckhardt
(a) Residence. No. St., 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 Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Single
6. DATE OF BIRTH (MONTH, DAY AND YEAR) January 25, 1908
7. AGE Years 21 Months 8 Days 8 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (CITY OR TOWN) St. Louis Co.
(STATE OR COUNTRY) Missouri.

PARENTS
10. NAME OF FATHER Peter Eckhardt
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Hungary
12. MAIDEN NAME OF MOTHER Magdalena Heisler
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Hungary.

14. INFORMANT Peter Eckhardt
(Address) 773 Lemay Ferry Rd.

15. FILED Oct 4, 1929 L. C. Obrock REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) October 2 1929
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 4.50 a.m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Chronic Endocarditis
(duration) yrs. mos. ds.
18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) John O'Connell Conner Hand Co. M.D.
10-2, 1929 (Address) 7171 Manchester

*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 Mt. Olive Cemetery
DATE OF BURIAL 10/5 1929
20. UNDERTAKER C. Hoffmeister U & L Co
ADDRESS 7814 S. Broadway

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.