

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

Do not use this space.

35502

1. PLACE OF DEATH

County..... Registration District No. 791
Township..... Primary Registration District No. 1003
City St. Louis (No. City St. Louis)
St. _____ Ward)

File No. _____
Registered No. 10252

2. FULL NAME John Eckhartz
(a) Residence No. 3901 Delmar St. 19 Ward. _____
(Usual place of abode) _____ (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 4 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 13 - 1866
7. AGE
YEARS 62 MONTHS 9 DAYS 25
If LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Sawyer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 18 1929
17. I HEREBY CERTIFY, that I attended deceased from Sept 20, 1929 to Oct 15, 1929, that I last saw him alive on Oct 15, 1929, and that death occurred, on the date stated above, at 1:35 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Abscess of Lung (Rt. L. Lobe)
(duration) _____ yrs. _____ mos. 14 ds.
CONTRIBUTORY (SECONDARY) Broncho Pneumonia
(duration) _____ yrs. _____ mos. 2 ds.

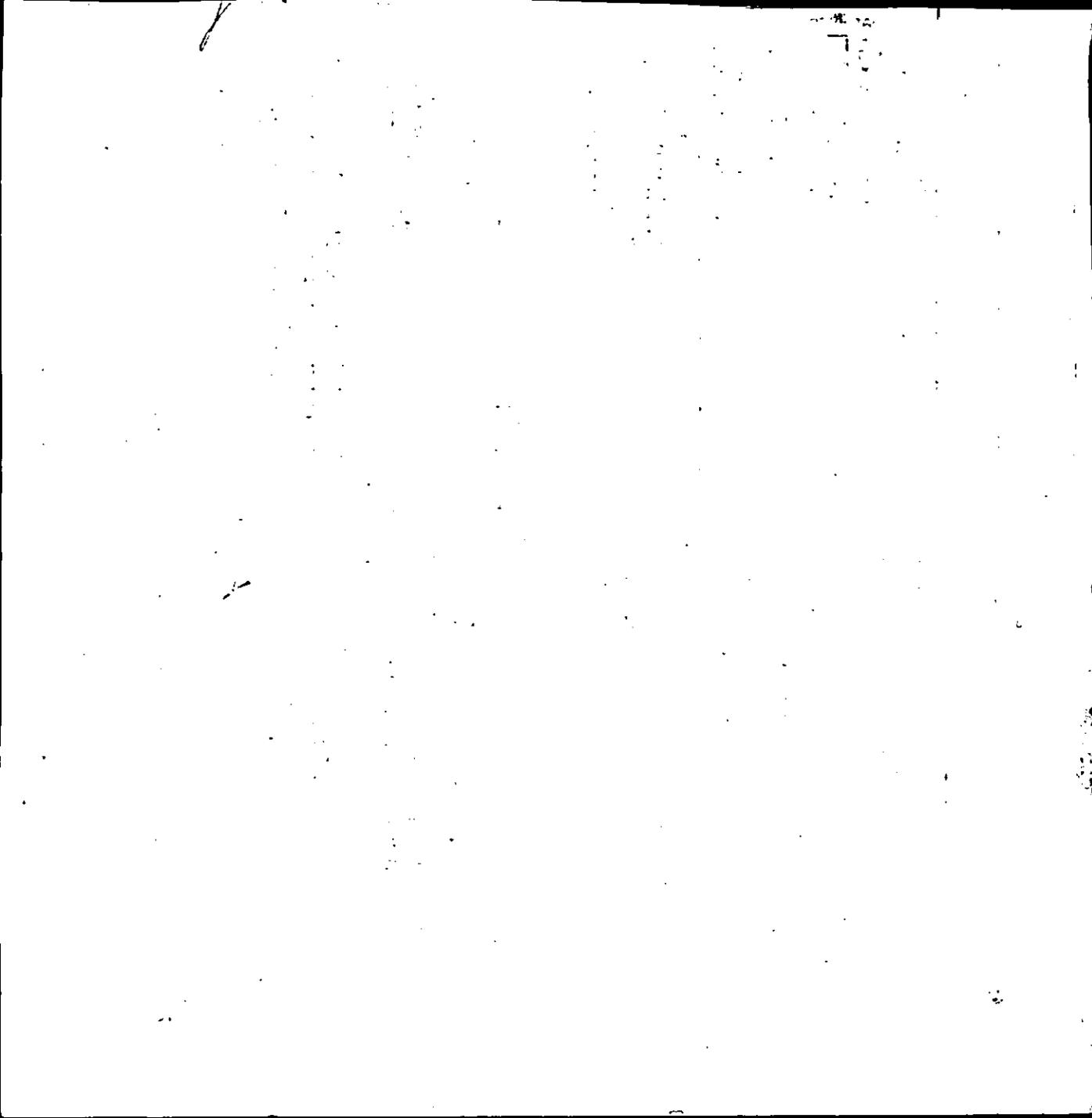
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri
10. NAME OF FATHER John Eckhartz
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

18. WHERE WAS DISEASE CONTRACTED 3901 Delmar
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? X-ray chest
(Signed) B. Margulies, M. D.
109 18, 1929 (Address) City St. Louis

*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.

14. INFORMANT (Address) City St. Louis
15. FILED Oct 19 1929 Max C. Stahler REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL S.S. Peter & Paul **DATE OF BURIAL** Oct 27 1929
20. UNDERTAKER Stross & Carroll **ADDRESS** 4600 Wall Bldg



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ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis (No.) St. Ward)

2. FULL NAME

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (use the word) wid

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

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

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

10. NAME OF FATHER

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 (Address)

15. FILED 2 19 1929 Mary C. Parker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 18 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..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.
 , 19 (Address)

*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 DATE OF BURIAL 19

20. UNDERTAKER Shook & Carroll ADDRESS

SUPPLEMENTARY

PARENTS

1929
35502