

FEB 12 1938

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

782
Do not use this space.

1. PLACE OF DEATH

St. Louis Maternity Hospital

(a) County Registration District No. **791**
 (b) Township Primary Registration District No. **1003** Registered No. **638**
 (c) City, **Saint Louis, Mo.** (d) Street No. **Saint Louis Maternity Hospital** St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Infant Eek **2-50**

(a) Residence, No. **305 Atlanta Ave. Webster Groves** **NR** **Webster Groves Mo.**
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Undetermined White

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **1 - 14 - 38**

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

Stillborn

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Saint Louis, Missouri**

FATHER 13. NAME **John Landen Eek**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis, Mo.**

MOTHER 15. MAIDEN NAME **Lois Morehouse**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Toledo, Ohio**

17. INFORMANT (ADDRESS) **John Landen Eek**
305 Atlanta Ave

18. BURIAL, CREMATION, OR REMOVAL PLACE **Wash. Univ** DATE **JAN 19 1938**

19. FUNERAL DIRECTOR (ADDRESS) **Dept of Pathology**
Missouri State Hosp

20. FILED **Jan 19 1938** **J. J. Braddock** Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **1-14-1938** 19.....

22. I HEREBY CERTIFY, That I attended deceased from, 19....., to, 19.....

I last saw h..... alive on, 19..... Death is said to have occurred on the date stated above, at **7:30** A.M.

The principal cause of death and related causes of importance were as follows:

Amnesia 20 weeks

Date of onset

Other contributory causes of importance:

Name of operation Date of
 What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury, 19.....
 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify **H. Hauptman** M. D.
 (Signed) **St. Louis Maternity Hosp.**
 (Address)

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

50M-7-26-37 I X12004

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.

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STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.
hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....
..... L. E.
No..... or by....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.)