

REC'D MAR 23 1939

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

Do not use this space.

## 1. PLACE OF DEATH

County *St. Charles*  
Township *St. Charles*  
City *St. Charles Mo.* (No. \_\_\_\_\_)

Registration District No. *757*  
Primary Registration District No. *3036*

File No. *7654*  
Registered No. *14*  
St. \_\_\_\_\_ Ward \_\_\_\_\_

## 2. FULL NAME

*Erwin Echelmeier*

(a) Residence, No. *1/2 mile south W. of St. Charles, Cornalick road* Ward \_\_\_\_\_  
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *25* yrs. *3* mos. *18* ds. How long in U. S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>male</i>	4. COLOR OR RACE <i>white</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>single</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>son of Mr. &amp; Mrs. Wm. Echelmeier</i>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>10-28-1913</i>		
7. AGE	YEARS <i>25</i>	MONTHS <i>3</i>
	DAYS <i>18</i>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>farm labor</i>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <i>farming</i>	
	10. Date deceased last worked at this occupation (month and year) <i>1-1-1937</i>	11. Total time (years) spent in this occupation <i>4 1/2</i>

12. BIRTHPLACE (CITY OR TOWN) *St. Charles Co. Mo.* (STATE OR COUNTRY) *Mo.*

13. NAME *Wm. Echelmeier*

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

15. MAIDEN NAME *Louise Westemeier*

16. BIRTHPLACE (CITY OR TOWN) *St. Charles Co. Mo.* (STATE OR COUNTRY)

17. INFORMANT *Wm. Echelmeier* (ADDRESS) *St. Charles Mo. R.R. 2*

18. BURIAL, CREMATION, OR REMOVAL  
PLACE *Friedman Cemetery* DATE *July 13<sup>th</sup>* 1939

19. UNDERTAKER *Steinbrenner, Hud. Co.* (ADDRESS) *St. Charles, Mo.*

20. FILED *2/13* 1939 *Clarence H. Messler* Registrar. A.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *2-10-1939*

22. I HEREBY CERTIFY, That I attended deceased from *Aug. 19, 1937* to *Feb. 10, 1939*, 1939

I last saw him alive on *Feb. 10, 1939*. Death is said to have occurred on the date stated above, at *6 P.M.*

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

*Bilateral Stapleloecosis*  
*Abscesses of both kidneys*  
Date of onset *Aug 19 1937*

Other contributory causes of importance:

Name of operation *Drain of both kidneys* Date of *Dec 1937*

What test confirmed diagnosis? *X-Ray* 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 \_\_\_\_\_

(Signed) *T. R. Ferrier*, M. D.

(Address) *St. Charles Mo.*

*D. B. G. Neuhueser*

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.

1322

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

7654  
Do not use this space.

1. PLACE OF DEATH

(a) County St. Charles Registration District No. 757  
(b) Township St. Charles Primary Registration District No. 5998 Registered No. \_\_\_\_\_  
(c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ 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 Erwin Echelmeier

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE YEARS 25 MONTHS 3 DAYS 18 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as bank 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)

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19\_\_

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED \_\_\_\_\_ 19\_\_

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2 - 10 - 1937

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

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

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

Bilateral Staphylococci abscess of both kidneys  
# N.M.D.#  
Date of onset 1937

Other contributory causes of importance:

No. J. G. 132

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 \_\_\_\_\_ (Signed) T. J. Hardin, M. D.

(Address) St. Charles Mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY MOORE  
N. B. Every item of information should be checked in plain terms, and a statement of occupation of every important

SUPPLEMENTARY

