

Registration District No. **784** Primary Registration District No. **307**

1. PLACE OF DEATH:
 (a) County **St. Louis County**
 (b) City or town **Afton**
 (c) Name of hospital or institution:
8631 Charlton
 (d) Length of stay: In hospital or institution _____
 In this community _____

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo.** (b) County **St. Louis**
 (c) City or town **Afton**
 (d) Street No. **8631 Charlton**
 (e) Citizen of foreign country? **No.**

3. (a) PRINT FULL NAME **Anna Eichhorn**
 3. (b) If veteran, name war _____
 3. (c) Social Security No. **None**

4. Sex **female** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Widowed**
 6. (b) Name of husband or wife **Eward Eichhorn**
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **Mar 2 1866**

8. AGE: Years **76** Months **4** Days **16**
 If less than one day _____ hr. _____ min.

9. Birthplace **St. Louis** (City, town, or county) (State or foreign country) **0**

10. Usual occupation **At Home**

11. Industry or business _____

MOTHER FATHER {
 12. Name **Gerhardt Groene**
 13. Birthplace **Germany**
 14. Maiden name **Mary Lammert**
 15. Birthplace **Germany**

16. (a) Informant **Geo. Pallard**
 (b) Address **8631 Charlton**

17. (a) **Burial** (b) Date thereof **July 21, 1942**
 (c) Place: burial or cremation **Old SS Peter & Paul**

18. (a) Signature of funeral director **John H. Hicken Sons**
 (b) Address **2630 Gravois**

19. (a) **JUL 20 1942** (b) Registrar's signature **L. W. Sargent**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **18** year **1942** hour **9:30A.M.** minute _____ M. _____
 21. I hereby certify that I attended the deceased from **July 17** to **July 18**
 that I last saw him alive on **July 17** and that death occurred on the date and hour stated above.

Immediate cause of death **chronic myocarditis 6 mo.**
 Due to **arterio-sclerosis**

Due to _____
 Other conditions **ASD**
 (Include pregnancy within 3 months of death)

Major findings: Of operations **none**
 Of autopsy **none**
 PHYSICIAN _____

22. If death was due to external causes, fill in the following: **no**
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (e) Means of injury **heart**
 Signature **W. H. Sargent** (M. D. or other) **MD**
 Address **5318 S. Grand** Date signed **July 19 1942**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

96
0
0

96
0

109

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Robert F. Gebken*

Licensed Embalmer No. 4144

P. O. Address. 2630 Gravois

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.)

If this body is not embalmed, fact should be so stated above.