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DEPARTMENT OF COMMERCE
 STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. **318** Primary Registration District No. **1002** Registrar's No. **5740**

1. PLACE OF DEATH:
 (a) County **St. Louis, Missouri**
 (b) City or town **St. Louis, Missouri**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis City Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **3 Mos., 12 Days**
 In this community **2 Yrs.**
 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **12**
 (c) City or town **St. Louis**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **No Home** (If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country.

3. (a) PRINT FULL NAME **Edward Joseph Etchey**
 3. (b) If veteran, name war **Unknown** 3. (c) Social Security No. **Unknown**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced, **Divorced**
 6. (b) Name of husband or wife **Unknown** 6. (c) Age of husband or wife if alive **Unknown** years
 7. Birth date of deceased **May 18, 1878**
 (Month) (Day) (Year)

8. AGE: Years **64** Months **12** Days **0** 18
 If less than one day hr. min.

9. Birthplace **Indiana**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Cook**

11. Industry or business **Nil.**

12. Name **Frank Etchey**

13. Birthplace **Pennsylvania**
 (City, town, or county) (State or foreign country)

14. Maiden name **Lavine (Unknown)**

15. Birthplace **Germany**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Ann P. Morrison**
 (b) Address **St. Louis City Hospital.**

17. (a) **Burial** (b) Date thereof **6 24 43**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **City Cemetery**

18. (a) Signature of funeral director **J. W. White**
 (b) Address **City Hospital, No. 1**
 19. (a) **JUN 23 1943** **J. F. Bradock**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **June** day **5**
 year **1943** hour **9:00** minute **P.** M.
 21. I hereby certify that I attended the deceased from **February 24, 1943** to **June 5, 1943**
 that I last saw him alive on **June 5, 1943**
 and that death occurred on the date and hour stated above.

Immediate cause of death
Generalized syphilis
arteriosclerotic heart disease
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)
Organic psychosis 3 1/2
 Major findings:
 Of operations
 Of autopsy **above confirmed**

Duration
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify).....
 (b) Date of occurrence.....
 (c) Where did injury occur?.....
 (City or town) (County) (State)
 (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.....
 23. Signature **Homer Sweetman, MD** (M. D. or other)
 Address **1515 Lafayette** Date signed **6-4-43**

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

MOTHER FATHER

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.....

Licensed Embalmer No.....

P. O. Address.....

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.