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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED JAN 20 1944

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 193

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

(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  
Max C. Starkloff Memorial  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 4 days  
(Specify whether)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 226a Victor St.  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Ella Eich

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Clarence Eich

6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased September 4, 1888  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 4  
year 1944 hour 2:00 minute P M.

21. I hereby certify that I attended the deceased from January 1, 1944 to January 4, 1944; that I last saw her alive on January 4, 1944; and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>55</u>	<u>4</u>	<u>0</u>	hr. min.

9. Birthplace St. Charles Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

Immediate cause of death encephalomalacia

Due to Syphilis

Due to \_\_\_\_\_

Other conditions gk  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy encephalomalacia

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

11. Industry or business \_\_\_\_\_

12. Name Steve Furlong

13. Birthplace St. Charles, Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Aubuchon

15. Birthplace St. Louis, Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Clarence Eich

(b) Address 226a Victor St.

17. (a) Burial (b) Date thereof Jan. 8, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Marcus Cm.

18. (a) Signature of funeral director. Weick Bros.

(b) Address 2201 S. Grand Bl.

19. (a) JAN 7 1944 (b) J.F. Bredeck  
(Date received local registrar) (Registrar's signature)

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 Chas. J. Wade (M, D, or other) 1/8/44  
Address 1515 Lafayette Avenue Date signed \_\_\_\_\_

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

**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..... *Wm. A. Stewart*

Licensed Embalmer No..... 3722

P. O. Address..... 412 Duchouquette S

**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.**