

FILED JUN 19 1948

State File No. _____

Registration District No. _____

Primary Registration District No. _____

Registrar's No. **5211**

1. PLACE OF DEATH:

(a) County _____
 (b) City or town **St. Louis**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Missouri-Baptist Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 years, months or days) **0**

3. (a) PRINT FULL NAME **Carl Eichorn**

3. (b) If veteran, name war **None**
 3. (c) Social Security No. **489-10-1203**

4. Sex **Male** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **October 27 1905**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
38 7 8 hr. _____ min.

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

10. Usual occupation **Shoe Salesman**11. Industry or business **Lee Shoe Stores, Inc.**12. Name **John Eichorn**13. Birthplace **Unknown Russia**
(City, town, or county) (State or foreign country)14. Maiden name **Charlotte Fretzler**15. Birthplace **Unknown Russia**
(City, town, or county) (State or foreign country)16. (a) Informant **E.J. Eichorn**(b) Address **Oklahoma City, Okla.**17. (a) **Removal** (b) Date thereof **6-5-44**
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **Oklahoma City, Okla.**18. (a) Signature of funeral director **Albert H. Hoppe**(b) Address **4700 Washington Blvd.**19. (a) **JUN 7 1948** (b) **J. F. Bruesch**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
 (c) City or town **St. Louis**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **5960 Theodosia Ave.**
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **5**
 year **1944** hour **6** minute **A. M.**

21. I hereby certify that I attended the deceased from **May 31**
 19**44**, to **June 5**, 19**44**.

that I last saw h. **alive on June 4** and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary occlusion** Duration **2 1/2 hrs.**

Due to _____

Due to _____

Other conditions **Pulmonary infarction of lower left lobe.**
 (Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____

Of autopsy _____

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)
 (c) Means of injury _____

23. Signature **J. Lincoln First** (M. D. or other) **D.O.**Address **15106 Hochman** Date signed **June 5, '44**

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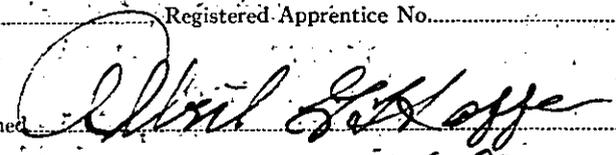
STATEMENT BY LICENSED EMBALMER

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.....

2971

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.