S. No. 2
DM—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 14 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

25604

State File No. 25604

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7808

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: St. Johns 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)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5808 Vernon Ave.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Clive LeRoy Ekiss
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Male
5. Color or race White
6. (a) Single, married, widowed, divorced Married
6. (b) Name of husband or wife Merel B. Ekiss
6. (c) Age of husband or wife if alive 51 years
7. Birth date of deceased Jan. (Month) 20 (Day) 1891 (Year)

8. AGE: Years 54 Months 7 Days 15 If less than one day hr. min.

9. Birthplace Ill. (City, town, or county) (State or foreign country)
10. Usual occupation Accountant
11. Industry or business M.K.& T. Railroad

FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant Robert Ekiss
(b) Address Geo. Washington Hotel
17. (a) removal (Burial, cremation, or removal) (b) Date thereof 9-6-45 (Month) (Day) (Year)
(c) Place: burial or cremation Decatur - Ill
18. (a) Signature of funeral director Drehmann-Harral
(b) Address 1905 Union Blvd.
19. (a) SEP 6 1945 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 5 year 1945 hour 7 minute 45 A. M.
21. I hereby certify that I attended the deceased from Sept 2, 1945, to Sept 5, 1945, that I last saw him alive on Sept 4, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death: Pneumonia, lobar — Duration 1 wk
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy Lobar pneumonia, left

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature [illegible] (M. D. or other) M.D.
Address 402 Lister Bldg. Date signed 9/5/45

(Licensed Embalmer's Statement on Reverse Side)

Dr. Victor Kierter, (Fo.5800)
4500 Olive St. Lister Bldg.

1 2 30 to 3 = Recording

6900 Cornell

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 Warren A. Carver

Licensed Embalmer No. 353x

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.