V. S. No. 2
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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

31634

State File No. 9324

FILED NOV 2 1945

Registration District No. 18

Primary Registration District No. 1003

Registrar's No.

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

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 2mos-14 days (Specify whether
In this community 18 years
years, months or days)

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. City Infirmary
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME HILDA ADAMS
3. (b) If veteran, name war
3. (c) Social Security No. O.A.A.
4. Sex female
5. Color or race white
6. (a) Single, widowed, married, divorced widow
6. (b) Name of husband or wife unk
6. (c) Age of husband or wife if alive years
7. Birth date of deceased December 14th, ?? (Month) (Day) (Year)

8. AGE: Years 74? Months Days If less than one day hr. min.

9. Birthplace Mass. (City, town, or county) (State or foreign country)
10. Usual occupation unk
11. Industry or business
FATHER
12. Name Bernard Echberg
13. Birthplace unk (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Beata Unk
15. Birthplace Unk (City, town, or county) (State or foreign country)
16. (a) Informant M. Renard
(b) Address St. Louis City Hospital
17. (a) Anatomical Board (Burial, cremation, or removal) (b) Date thereof 10-18-45 (Month) (Day) (Year)
(c) Place: burial or cremation Washington
18. (a) Signature of funeral director W. Richter
(b) Address 3000 Rutgers
19. (a) OCT 29 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 12th
year 1945 hour 5:15 minute P. M.
21. I hereby certify that I attended the deceased from 7/28/45, 19, to 10/12/45, 19;
that I last saw her alive on 10/12/45, 19;
and that death occurred on the date and hour stated above.

Immediate cause of death: Post Pneumonic Empyema

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations Empyema
Non-tuberculous
Of autopsy 0

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

23. Signature [signature] (M. D. or others)
Address 1515 Lafayette 10/13/45 Date signed

(Licensed Embalmer's Statement on Reverse Side)

APR 22 1948

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.