

FILED MAR 19 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

9988

No. 300  
10-48

~~318~~

~~1003~~ 318

1003

State File No. ....

2250

BIRTH NO. <del>318</del>		REG. DIST. NO. <del>1003</del> 318		PRIMARY REG. DIST. NO. 1003		State File No. ....		9988		
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE Missouri b. COUNTY St. Louis						
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			c. LENGTH OF STAY (In this place) 1 day		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Webster Groves 967					
d. FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital				d. STREET ADDRESS (If rural, give location) 515 Greeley Ave. A 4						
3. NAME OF DECEASED (Type or Print) a. (First) Albin			b. (Middle) Carl		c. (Last) Eek		4. DATE OF DEATH (Month) (Day) (Year) March 9th. 1949			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widower		8. DATE OF BIRTH Mar. 10, 1872		9. AGE (In years last birthday) 76 1/4		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Sweden 4		12. CITIZEN OF WHAT COUNTRY? U.S.		
13a. FATHER'S NAME Klaus Eek			13b. MOTHER'S MAIDEN NAME Anna Kajsa			14. NAME OF HUSBAND OR WIFE Josephine Eek				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 488-09-0324		17. INFORMANT'S SIGNATURE OR NAME John Eek				ADDRESS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH 28 hrs.		
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary & thrombosis								
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) 94								
		DUE TO (c) 4201								
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)						
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?						
22. I hereby certify that I attended the deceased from Mar 8, 1949, to Mar 9, 1949, that I last saw the deceased alive on Mar 9, 1949, and that death occurred at 2:15 P.M., from the causes and on the date stated above.										
23a. SIGNATURE Bernard M. Kraus M.D.				23b. ADDRESS 3101 S. Grand St.		23c. DATE SIGNED 3-11-49				
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3/12/49		24c. NAME OF CEMETERY OR CREMATORY Oak Hill		24d. LOCATION (City, town, or county) (State) Kirkwood, Mo.				
DATE REC'D BY LOCAL REG. Mar 11 1949		REGISTRAR'S SIGNATURE J. B. Laster			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Parker Undt. Co. Webster Groves, Mo					

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

MAY 01950

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.....

..... Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed Leslie Welch  
Licensed Embalmer No. 4395

P. O. Address Wester Grove

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.