

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 29 1949

State File No. **34808**

BIRTH NO. _____ REG. DIST. NO. **300** PRIMARY REG. DIST. NO. **3058** Registrar's No. **193**

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

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY St Charles | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St Charles | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Charles | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Charles | |
| c. LENGTH OF STAY (in this place) 81 yrs | | d. STREET ADDRESS (If rural, give location) 727 Monroe St | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 727 Monroe St / | | | |

| | | | |
|--|----------------------------|--------------------------|--|
| 3. NAME OF DECEASED (Type or Print) | | 4. DATE OF DEATH | |
| a. (First) Robert | b. (Middle) Jeck | c. (Last) Jeck | (Month) (Day) (Year) October 17 1949 |

| | | | | | | | | |
|--------------------|------------------------------|--|--|--|---------------------------|-------------------------|---------------------------|--------------------------|
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH April 24 1868 | 9. AGE (In years last birthday) 81 | IF UNDER 1 YEAR Months | IF UNDER 1 YEAR Days | IF UNDER 14 HRS. Hours | IF UNDER 14 HRS. Min. |
|--------------------|------------------------------|--|--|--|---------------------------|-------------------------|---------------------------|--------------------------|

| | | | |
|---|-----------------------------------|---|--|
| 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) St Charles Mo | 12. CITIZEN OF WHAT COUNTRY? U.S.A |
|---|-----------------------------------|---|--|

| | | |
|--|--|--|
| 13a. FATHER'S NAME George Jeck | 13b. MOTHER'S MAIDEN NAME Wilhelmina Spies | 14. NAME OF HUSBAND OR WIFE Lydia Wille Jeck |
|--|--|--|

| | | | |
|---|---|--|---|
| 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. 488-167377 None | 17. INFORMANT'S SIGNATURE OR NAME Wilma Jeck | ADDRESS 727 Monroe St Charles |
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|---|---|--|---|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH 2 wks 10 yrs - 3 3/4 |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Gen. arterio sclerosis DUE TO (c) | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |
| 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) m. | 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 **9/10**, 19**46**, to **10/17**, 19**49**, that I last saw the deceased alive on **10/14**, 19**49**, and that death occurred at **7:49** m., from the causes and on the date stated above.

| | | | |
|--|--------------------------------|---|-------------------------------------|
| 23a. SIGNATURE R. H. [Signature] | (Degree or title) MD | 23b. ADDRESS 126 So Main St St Charles Mo | 23c. DATE SIGNED 10/28/49 |
|--|--------------------------------|---|-------------------------------------|

| | | | |
|--|-------------------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE October 19 1949 | 24c. NAME OF CEMETERY OR CREMATORY St John's Cemetery | 24d. LOCATION (City, town, or county) (State) St Charles Co Mo |
|--|-------------------------------------|---|--|

| | | | |
|---|---|--|-----------------------------|
| DATE REC'D BY LOCAL REG. 10-26-49 | REGISTRAR'S SIGNATURE [Signature] | 25. FUNERAL DIRECTOR'S SIGNATURE [Signature] | ADDRESS [Address] |
|---|---|--|-----------------------------|

District File Number

District Health Officer No. 9,

OCT 28 1949

RECEIVED

1949

DEC 9

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.

Signed..... *Arthur C. Bane*

Signed.....
Student Embalmer

Licensed Embalmer No. *3155*

P. O. Address *St Charles Mo.*

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.