

STANDARD CERTIFICATE OF DEATH

State File No. **42199**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10905**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 20591	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hospital		e. STREET ADDRESS (If rural, give location) 6160 Waterman 0	
3. NAME OF DECEASED (Type or Print) Sarah S. Eckert		4. DATE OF DEATH (Month) (Day) (Year) Dec 20 1950	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH April 15, 1870
9. AGE (In years last birthday) 80		10. MONTHS 8	11. DAYS 5
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Russia 6		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME Charles Schwartzman	13b. MOTHER'S MAIDEN NAME Mary Measuroff	14. NAME OF HUSBAND OR WIFE Louis Eckert
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Mrs. Hazel Davis-6160 Waterman Ave.

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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 10 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis General. 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 type="checkbox"/>
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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? 232X

22. I hereby certify that I attended the deceased from **12/10**, 19**50**, to **12-20**, 19**50**, that I last saw the deceased alive on **12-20**, 19**50**, and that death occurred at **8A** m., from the causes and on the date stated above.

23a. SIGNATURE Herman M. Meyer M.D. (Degree or title)	23b. ADDRESS 508 N. Grand	23c. DATE SIGNED 12/21/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12/22/50	24c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. DEC 21 1950	REGISTRAR'S SIGNATURE J. B. Lasater	25. FUNERAL DIRECTOR'S SIGNATURE Herman Rudolph, Inc. 5216 Delmar	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

.....
working under my personal supervision.

Signed.....
Student Embalmer

Student Embalmer No.....

Signed

John Ketter
Licensed Embalmer No. 3880

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.