

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15643**
Registrar's No. **3995**

FILED MAY 14 1953

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Mo.		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Christian Hospital		e. STREET ADDRESS (If rural, give location) 6108 N. Broadway			
3. NAME OF DECEASED (Type or Print) a. (First) Josephine b. (Middle) Furey c. (Last) Eckert		4. DATE OF DEATH (Month) (Day) (Year) April 16 1953			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept 7 1891	9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months Days 7 9
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo	
13a. FATHER'S NAME Joseph Repple		13b. MOTHER'S MAIDEN NAME Mary Huber		14. NAME OF HUSBAND OR WIFE Peter H. Eckert	
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.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Peter H. Eckert 6108 N. Broadway	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 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) Hypertension DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Paralysis of left side			INTERVAL BETWEEN ONSET AND DEATH 12 da Scit hour 12 da
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION Paralysis		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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 331X	
22. I hereby certify that I attended the deceased from April 5, 1953 , to 4/16, 1953 , that I last saw the deceased alive on April 16, 1953 , and that death occurred at 4:40 p.m. , from the causes and on the date stated above.					
23a. SIGNATURE Grace H. Mountain M.D.		23b. ADDRESS 4032 N. Florissant Ave		23c. DATE SIGNED 4/17/53	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE April 20		24c. NAME OF CEMETERY OR CREMATORY Calvary	
		24d. LOCATION (City, town, or county) (State) St. Louis Mo.			
DATE REC'D BY LOCAL REG. APR 17 1953		REGISTRAR'S SIGNATURE J. C. Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Buchholz-Koeller 5967 W. Florissant	

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.....
Signature of Student Embalmer

Signed *W. Alfred G. Brashley*.....

Licensed Embalmer No. *4551*.....

P. O. Address *St. Louis*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.