

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22814**
Registrar's No. **5768**

FILED JUN 24 1953

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY 2269	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis Mo 0		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION DePaul Hospital		d. STREET ADDRESS (If rural, give location) 20 2115 Palm St.	

3. NAME OF DECEASED (Type or Print) a. (First) Albert b. (Middle) Eckhoff c. (Last) Eckhoff			4. DATE OF DEATH (Month) (Day) (Year) June 9 1953			
5. SEX MALE 0	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JAN. 30 1894	9. AGE (In years last birthday) 59	IF UNDER 1 YEAR Months Days	IF UNDER 1 HOUR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed		10b. KIND OF BUSINESS OR INDUSTRY - 0 -		11. BIRTHPLACE (State or foreign country) ST. LOUIS 0		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Clemens Eckhoff		13b. MOTHER'S MAIDEN NAME Mary Schroeder		14. NAME OF HUSBAND OR WIFE Mary Eckhoff	
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. 500-24-790		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mary Eckhoff 2115 Palm St.	

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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myelogenous Leukemia ANTECEDENT CAUSES Pneumonia Myocarditis Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH 6 mos 3 das	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) St Louis MO MO	
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 2041	

22. I hereby certify that I attended the deceased from **June 6, 1953** to **June 9, 1953**, that I last saw the deceased alive on **June 9, 1953**, and that death occurred at **8:10 am.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) [Signature]		23b. ADDRESS 1875 Madison		23c. DATE SIGNED 6/10/53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE June 11 1953		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
24d. LOCATION (City, town, or county) (State) St Louis Missouri		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Central Funeral Home 5541 Riverview Pl.			
DATE REC'D BY LOCAL REG. JUN 10 1953		REGISTRAR'S SIGNATURE [Signature]			

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Ben Hoffman

Licensed Embalmer No. 4366

P. O. Address St Louis 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.