

FILED JUL 1-1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20421

State File No.

318

1003

Registrar's No. 5099

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

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)	
b. CITY (If outside corporate limits, write RURAL and give town or township) ST. LOUIS, MISSOURI		c. CITY OR TOWN OVERLANDS	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL		e. STREET ADDRESS 2245 Wengler	

3. NAME OF DECEASED (Type or Print)	a. (First) WALTER	b. (Middle)	c. (Last) ECKERT	4. DATE OF DEATH	(Month) JUNE	(Day) 6,	(Year) 1954
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5. SEX MALE <input checked="" type="radio"/>	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married <input checked="" type="radio"/>	8. DATE OF BIRTH MAY 24, 1891	9. AGE (In years last birthday) 63	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY various jobs	11. BIRTHPLACE (City and State or foreign Country) St. Louis	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME FRED Eckert	13b. MOTHER'S MAIDEN NAME KATHRYN Humpke	14. NAME OF HUSBAND OR WIFE None
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME AUGUSTA ROSSER Hunter	ADDRESS 2245-Wengler
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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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Infarction		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) or Myocardial Infarction		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Acute Brain Syndrome			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? H65X
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22. I hereby certify that I attended the deceased from 5-15-54, 19, to 6-6-54, 19, that I last saw the deceased alive on 6-6-54, 19, and that death occurred at 2:15P m., from the causes and on the date stated above.

23a. SIGNATURE Sam J. Joseph M.D.	23b. ADDRESS 1515 Lafayette Avenue	23c. DATE SIGNED 6-7-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6-9-1954	24c. NAME OF CEMETERY OR CREMATORY St. Matthews Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. JUN 8 1954	REGISTRAR'S SIGNATURE J. Carl Smith MO	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 2504 Woodson Rd. Overland, Mo.
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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 *David C. Gibson*

Licensed Embalmer No. *341*

P. O. Address *Overland*

**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.**