

FILED NOV 22 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38692**
Registrar's No. **9911**

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

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

| | | | | | | | | | |
|---|--|--|--|---|---|--|--|---|--|
| BIRTH NO. _____ | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. NO. 1003 | | State File No. 38692 | | Registrar's No. 9911 | |
| 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 town) St. Louis | | | c. LENGTH OF STAY (in this place) (township) 11 days | | c. CITY OR TOWN St. Louis | | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Baptist Hospital | | | | | 6. STREET ADDRESS (If rural, give location) 1629 Semple Avenue. 206/0 | | | | |
| 3. NAME OF DECEASED a. (First) GASKA | | | b. (Middle) L. ECKHOFF. | | c. (Last) _____ | | 4. DATE OF DEATH (Month) Oct (Day) 31 (Year) 1954 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | | 8. DATE OF BIRTH March 22, 1879 | | 9. AGE (In years last birthday) 75 | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HRS. Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (City and State or Foreign Country) Germany | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13a. FATHER'S NAME Libbe Janssen | | | 13b. MOTHER'S MAIDEN NAME Unknown | | 14. NAME OF HUSBAND OR WIFE Albert H. Eckhoff | | | | |
| 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 Mrs. Edith Cameron ADDRESS 1135 Lawn Avenue. | | | | |
| 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) Pulmonary embolism | | | | | | INTERVAL BETWEEN ONSET AND DEATH 7 Days | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cardio-vascular - Renal Disease | | | | | | 4 yrs. | | |
| | 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) _____ | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? 442X | | | | | |
| 22. I hereby certify that I attended the deceased from 10/20 , 19 54 , to 10/31 , 19 54 , that I last saw the deceased alive on 10/31 , 19 54 , and that death occurred at 4 P. m. , from the causes and on the date stated above. | | | | | | | | | |
| 23a. SIGNATURE Joseph P. Treigs, M.D. (Degree or title) _____ | | | | 23b. ADDRESS 508 N. Grand | | | 23c. DATE SIGNED 11/1/54 | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE Nov 3, 1954 | 24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery | | 24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri. | | | | |
| DATE REC'D BY LOCAL REG. NOV 1 1954 | | REGISTRAR'S SIGNATURE [Signature] | | | 25. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS Shepard Funeral Home, 1167 Hamilton Ave | | | | |

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..... *Paul A. Wachter*

Licensed Embalmer No. *478*

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.