

FILED JAN 6 1956

THE DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

42012

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10901**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <b>St. Louis</b> d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Park Lane Hosp</b>		e. STREET ADDRESS <b>3302 Oxford</b>		3 <b>20390</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Archie</b> b. (Middle) <b>W</b> c. (Last) <b>Eckert</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Dec 11 1955</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	
8. DATE OF BIRTH <b>April 20 1885</b>		9. AGE (In years last birthday) <b>70</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance</b>	
11. BIRTHPLACE (City and State or Foreign Country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		10b. KIND OF BUSINESS OR INDUSTRY	

13a. FATHER'S NAME <b>Peter Eckert</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Blaze</b>		14. NAME OF HUSBAND OR WIFE	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>486 12 4615</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Emma Cassidy</b> ADDRESS <b>7221 South Ave</b>	
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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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Occlusion</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>none known</b> DUE TO (c) <b>none known</b>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>no</b>				INTERVAL BETWEEN ONSET AND DEATH <b>18 hours</b>	
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19a. DATE OF OPERATION <b>no</b>		19b. MAJOR FINDINGS OF OPERATION <b>no</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>no</b>		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) <b>no</b>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from 10 Dec, 1955 to 11 Dec, 1955, that I last saw the deceased alive on 11 Dec, 1955, and that death occurred at 9:15A m., from the causes and on the date stated above.

23a. SIGNATURE <b>John R. Briscoe</b> (Degree or title) <b>MD</b>		23b. ADDRESS <b>Maplewood Mo</b>		23c. DATE SIGNED <b>12/11/55</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Dec 14 1955</b>		24c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Mo</b>	
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DATE REC'D BY LOCAL REG. <b>DEC 13 1955</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>E.J. Schnur</b> ADDRESS <b>3125 Lafayette</b>	
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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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Joseph B. Hallman*

Licensed Embalmer No. *4014*

P. O. Address *3195 Lehigh*

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.