

THE DIVISION OF HEALTH OF MISSOURI  
**FILED MAR 5 1956**      **STANDARD CERTIFICATE OF DEATH**

State File No. **6405**  
 Registrar's No. **1505**

|  |  |  |   |   |   |   |  |   |  |
|--|--|--|---|---|---|---|--|---|--|
| BIRTH NO. _____  |  | REG. DIST. NO. <b>318</b>  |   | PRIMARY REG. DIST. NO. <b>1003</b>  |   | State File No. <b>6405</b>  |  |   |  |
| REGISTRAR'S NO. <b>1505</b>  |  |  |   |   |   |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY   |  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).  |   |   |  |   |  |
|  |  |  |   | a. STATE<br><b>Missouri</b>   |   | b. COUNTY   |  |   |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN<br><b>St. Louis</b>   |  | c. LENGTH OF STAY (in this place)  |   | c. CITY OR TOWN<br><b>St. Louis</b>   |   | d. Is Residence within limits of a city or incorporated town?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |  |   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Firman-Desloge Hospital</b>  |  |  |   | e. STREET ADDRESS (If rural, give location)<br><b>2037 Knox Ave</b>   |   | <b>2037</b>   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or Print)   |  |  | a. (First)<br><b>AUGUST</b>                             |   | b. (Middle)<br><b>W.</b>                    |   | c. (Last)<br><b>ECKERT Jr.</b>                     |   |  |
| 4. DATE OF DEATH   |  | (Month) (Day) (Year)   |   | <b>2-9-1956</b>   |   |   |  |   |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>   |   | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>  |   | 8. DATE OF BIRTH<br><b>9-12-1881</b>  |  |   |  |
| 9. AGE (In years last birthday)  |  | IF UNDER 1 YEAR  |   | IF UNDER 24 HRS.  |   | Months Days Hours Mins.   |  |   |  |
| <b>74</b>  |  |  |   |   |   |   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Tile Setter</b> |   |   | 11. BIRTHPLACE (City and State or Foreign Country)<br><b>Missouri</b>   |  |   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  | 13a. FATHER'S NAME<br><b>August Eckert Sr</b>           |   | 13b. MOTHER'S MAIDEN NAME<br><b>Unknown</b> |   | 14. NAME OF HUSBAND OR WIFE<br><b>Lydia Eckert</b> |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>493-10-6053</b>  |   | 17. INFORMANT'S SIGNATURE OR NAME<br><i>Lydia Eckert</i>  |   | ADDRESS<br><b>2037 Knox Ave</b>   |  |   |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death. |  |  |   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Metastatic Carcinoma</b>  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>7 mos</b>                                    |  |
|  |  |  |   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>Carcinoma of sigmoid</b> |   |   |  | <b>18 mos</b>   |  |
|  |  |  |   | DUE TO (c)  |   |   |  |   |  |
|  |  |  |   | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.                             |   |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>9/6/57</b>  |  | 19b. MAJOR FINDINGS OF OPERATION<br><b>Carcinoma of sigmoid 153x</b>                                   |   |   |   |   |  | 20. AUTOPSY?<br>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)  |   | 21d. (COUNTY)   |  | 21e. (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?  |   |   |  |   |  |
| 22. I hereby certify that I attended the deceased from <b>9/1</b> , 19 <b>54</b> to <b>2/9</b> , 19 <b>56</b> and that death occurred at <b>11:10 A.M.</b> , from the causes and on the date stated above.                     |  |  |   |   |   |   |  |   |  |
| 23a. SIGNATURE<br><i>John J. Connor</i>  |  |  |   | 23b. ADDRESS<br><b>John J. Connor</b>   |   | 23c. DATE SIGNED<br><b>2/11/56</b>  |  |   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24b. DATE<br><b>2-15-1956</b>  |   | 24c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross Cemetery</b>  |   | 24d. LOCATION (City, town, or county) (State)<br><b>6638 Gravois Ave. Mo</b>  |  |   |  |
| DATE REC'D BY LOCAL REG.<br><b>FEB 14 1956</b>   |  | REGISTRAR'S SIGNATURE<br><i>Carl Smith</i>   |   | FUNERAL DIRECTOR'S SIGNATURE<br><i>Mo Siegenheim</i>  |   | ADDRESS<br><b>6409 Gravois Ave</b>  |  |   |  |
| (Licensed Embalmer's Statement on Reverse Side)  |  |  |   |   |   |   |  |   |  |

 About 10:30  
 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 *Van M. Seymour* .....

Licensed Embalmer No. *43* .....

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.