

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

28331

STATE FILE NUMBER

FILED AUG 24 1956

318

1003

6498

Registration District No. Primary Registration District No. Registrar's No.

Health, Welfare Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis,</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis,</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Homer Phillips</u>		Length of stay in 1b <u>19 Yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>19 4328 Forest Park</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Leroy</u> Last <u>Eickhorst</u>			4. DATE OF DEATH Month <u>July</u> Day <u>10</u> Year <u>1956</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 14, 1937</u>	9. AGE (In years last birthday) <u>19</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electric Co.</u>		11. BIRTHPLACE (City and state or country) <u>St. James, Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Arthur Eickhorst</u>		
14. MOTHER'S MAIDEN NAME <u>Audra Richeson</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		
16. SOCIAL SECURITY NO. <u>Nil.</u>			17. INFORMANT <u>Audra Eickhorst, 3101a N. Grand Ave</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Injury;</u> <u>Fracture of Skull;</u> DUE TO (b) <u>E 815.4</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO IMMEDIATE CAUSE OF DEATH <u>deceased collided with yellow Cab driven by</u> <u>Verdict by Judge of St. Louis, at the intersection of Taylor &amp; Westminster Ave., on July 9 1956 at about 4:20 pm, Cause of death maneuver same could not be determined</u>					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or 2 and 11 of item 18) <u>deceased collided with yellow Cab driven by</u>					
20c. TIME OF INJURY Hour <u>4:20</u> p. m. Month <u>7</u> Day <u>9</u> Year <u>1956</u>					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, (school, street, office bldg., etc.) <u>Street</u>		20f. CITY, TOWN, OR LOCATION <u>St. Louis Mo</u>	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>1220 P. m</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Patrick L. Taylor Coroner</u>			22b. ADDRESS <u>1300 Clark</u>		22c. DATE SIGNED <u>7-11-56</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>7-11-56</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Asher Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. James, Missouri.</u>
24. FUNERAL DIRECTOR <u>Albert H. Hoppe</u>		ADDRESS <u>4700 Washington</u>		25. DATE RECD. BY LOCAL REG. <u>JUL 11 1956</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith mo</u> <u>mgs</u>

(Licensed Embalmer's Statement on Reverse Side)

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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 *J. W. Binkley*.....

Licensed Embalmer No. *265*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.