

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011591

STATE FILE NUMBER

FILED APR 14 1959

Registration District No. 317

Primary Registration District No. 541

Registrar's No. 925

300
1-57

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN Clayton		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Wellston 4301
c. FULL NAME OF DECEASED (If in hospital, give location) St. Louis Co. Hospt.		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 6332 Theodosia
3. NAME OF DECEASED (Type or print) First John Middle R. Last Eskew		4. DATE OF DEATH Month 4 Day 3 Year 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-15-1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Industrail	11. BIRTHPLACE (City and state or country) Ill.
13a. FATHER'S NAME Richard Eskew		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Deceased
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address George E. Eskew 6416 Leschen Ave.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unknown Natural Cause			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 7954	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at 11:46A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Name or title) John C. Murphy MD Acting Health Commissioner		22b. ADDRESS 501 S. Brentwood Clayton	22c. DATE SIGNED
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-6-1959	23c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri
24. FUNERAL DIRECTOR ADDRESS Jos. W. Clark F.H. 1125 Hodiament		25. DATE RECD. BY LOCAL REG. 4-6-59	26. REGISTRAR'S SIGNATURE John C. Murphy, MD

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Alfred J. Brudeku*

Licensed Embalmer No. *2663*

P. O. Address *1125 Hudson*

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.