

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019122

STATE FILE NUMBER

FILED JUN 4 1959 Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. 4907

300  
1-57  
394  
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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>6719 MC CUNE</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>6719 MC CUNE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>RAYMOND</u> Middle <u>G</u> Last <u>ECKRICH</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>17</u> Year <u>1959</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 19 1917</u>	9. AGE (In years last birthday) <u>41</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NEVER WORKED</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>ST. LOUIS MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U-S-A</u>

13a. FATHER'S NAME <u>MARTIN ECKRICH</u>		13b. MOTHER'S MAIDEN NAME <u>ANNA KUPFERSCHMID</u>		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) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>MARTIN ECKRICH</u> Address <u>6719 MC CUNE</u>
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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>Coronary Occlusion</u>		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) <u>420.1</u>		
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.)		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____					
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, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	

21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her alive on \_\_\_\_\_  
Death occurred at 1200 MIDNITE on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Paul Simon</u>		22b. ADDRESS <u>1300 Clark</u>	22c. DATE SIGNED <u>5/20/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>MAY 21 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NEW ST. MARCUS</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO</u>
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24. FUNERAL DIRECTOR <u>Thomas Kuetis</u> ADDRESS <u>2906 Gravois</u>	25. DATE RECD. BY LOCAL REG. <u>MAY 20 '59</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u> <u>MDR</u>
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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 [Signature], Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student [Signature]  
Signature of Student Embalmer

Signed [Signature]

Licensed Embalmer No. 4347  
P. O. Address 2906 Howard

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.