

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022850
STATE FILE NUMBER
2 6241

FILED JUL 13 1959

Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS Mo</i>		c. CITY OR TOWN <i>ST. LOUIS</i>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>LUTHERAN HOSPITAL</i>		d. STREET ADDRESS (If outside, give location) <i>3521 PENNSYLVANIA</i>	
Length of stay in 1b		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>SANFRID J. EEK</i>			4. DATE OF DEATH Month Day Year <i>June 29 1959</i>
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MAY 30 1874</i>
9a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <i>RETIRED</i>	9b. KIND OF BUSINESS OR INDUSTRY	9c. AGE (In years last birthday) <i>85</i>	9d. F UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <i>SWEDEN</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>
13a. FATHER'S NAME <i>KLAUS EEK</i>		13b. MOTHER'S MAIDEN NAME <i>ANNA KAYSA</i>	
14. NAME OF HUSBAND OR WIFE <i>LOUIS EEK</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <i>LOUISE EEK</i>		Address <i>3521 PENNSYLVANIA</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac failure</i> DUE TO (b) <i>congestion lungs</i> 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 the terminal disease condition given in PART I (a) <i>senile dementia</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i> <i>3 weeks</i>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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.			
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 <i>4/22/58</i> to <i>6/29/59</i> and last saw her alive on <i>6/29/59</i> Death occurred at <i>5 PM</i> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Engene A Vogel M.D.</i>		22b. ADDRESS <i>3325 S Grand Bl</i>	
22c. DATE SIGNED <i>6/30/59</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>JULY 1959</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>NEW ST. MARCUS</i>		23d. LOCATION (City, town, or county) (State) <i>ST. LOUIS Mo</i>	
24. FUNERAL DIRECTOR <i>Thomas Kuter 2906 Beavis</i>		25. DATE RECD. BY LOCAL REG. <i>JUL 1 '59</i>	
26. REGISTRAR'S SIGNATURE <i>Neal Smith, M.D.</i>			

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 Eleana Province

Licensed Embalmer No. 3403

P. O. Address 2906 Grove

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.