

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-003349

FILED VS JAN 29 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 192** STATE FILE NUMBER

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|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Saint Louis | Length of stay in 1b 12 Hours | c. CITY OR TOWN Saint Louis (1) | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hosp. #1 | | d. STREET ADDRESS (If outside, give location) 509 Chestnut Street. | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|--|----------------------------------|---|---|--|---|
| 3. NAME OF DECEASED (Type or print) First Middle Last HARVEY A. EICHELBERGER | | | 4. DATE OF DEATH Month Day Year Jan. 6, 1960 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 3/31/92 | 9. AGE (last birthday) 67 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Advisor | | 10b. KIND OF BUSINESS OR INDUSTRY Self | 11. BIRTHPLACE (City and state or country) St. Louis, Mo. | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME Gordon Eichelberger | | 13b. MOTHER'S MAIDEN NAME Jennie Marschell | | 14. NAME OF HUSBAND OR WIFE None | |
| 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. 488-12-6591 | 17. INFORMANT Ferguson, Mo. Al Eichelberger 224 So. Barat | | |

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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) Trouble Pneumonia | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Arterio sclerosis | |
| | DUE TO (c) 450.0 | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
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| 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/him alive on _____.
Death occurred at **4:50 a.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

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|---|----------------------------------|---|--|-----------------------------------|
| 22a. SIGNATURE (Degree or title) Patrick Taylor | | 22b. ADDRESS 1300 Clark | | 22c. DATE SIGNED 1-7-60 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE Jan. 8, 1960 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery | 23d. LOCATION (City, town, or county) (State) Lemay (25) Mo. | |
| 24. FUNERAL DIRECTOR ADDRESS Fendler Und, Co. 7420 Michigan Ave. (11) | | 25. DATE RECD. BY LOCAL REG. JAN 7 1960 | 26. REGISTRAR'S SIGNATURE Loal Smith M.D. | |

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed W. G. Peterson

Licensed Embalmer No. 3767

P. O. Address 7420 M

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