

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

40759

1. PLACE OF DEATH

County.....
Township.....
City *St. Louis*

Registration District No. *791*
Primary Registration District No. *1003*
(No. *Christian Hospital*)

File No.
Registered No. *11398*
St. Ward

2. FULL NAME

Wilhelmenia Eckelmeier
(a) Residence No. *1102 E. College* St. *9* Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred *25* yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Female</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Married</i>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Wife of August Eckelmeier</i>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>Oct. 7, 1864</i>				
7. AGE	YEARS <i>66</i>	MONTHS <i>1</i>	DAYS <i>25</i>	IF LESS than 1 day,hrs. ormin.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <i>Housework</i> (b) General nature of industry, business, or establishment in which employed (or employer)..... (c) Name of employer.....				
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Westphalia Germany</i>				
PARENTS	10. NAME OF FATHER <i>Henry Wallbrink</i>			
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Not known Germany</i>			
	12. MAIDEN NAME OF MOTHER <i>unknown Liebert</i>			
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Not known Germany</i>				

14. INFORMANT..... *August Eckelmeier*
(Address) *1102 E. College*

15. FILED *Nov 24 1930* REGISTER

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec 3, 1930*
17. I HEREBY CERTIFY. That I attended deceased from *Nov 15, 1930* to *Dec 2, 1930* that I last saw him alive on *Dec 2, 1930* and that death occurred, on the date stated above, at *3 P. m.*

THE CAUSE OF DEATH WAS AS FOLLOWS:

Coronary Myocarditis
93 C
99 A
(duration) yrs. mos. *17* ds.
CONTRIBUTORY (SECONDARY) *embolus of the head*
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....
8 DID AN OPERATION PRECEDE DEATH DATE OF.....
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *G. M. Ross*, M. D.
. 19 (Address) *19189 Grand*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
St. John's Cem. St. Charles Mo. *Dec. 5, 1930*

20. UNDERTAKER ADDRESS
Guedmeyer & Co. *3934 N. 20*

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

