

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

Do not use this space.

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City *St. Louis Mo*

(No. *Isolation Hospital*)

File No. **18878**

Registered No. **5393**

St. .... Ward)

**2. FULL NAME** *Euseb Eschellback*

(a) Residence, No. *2426 S. Broadway 23* Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *7 1/2* yrs. mos. *05*

How long in U. S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *widower*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Nov 2 - 1960*

7. AGE YEARS *73* MONTHS *6* DAYS *26* IF LESS than 1 day, ..... hrs. or ..... min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *sight watchman*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Louis Missouri*

13. NAME *Euseb Eschellback*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *United States Missouri*

15. MAIDEN NAME *Missouri*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Missouri*

17. INFORMANT *Leona Burns* (ADDRESS) *5600 Arsenal*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Simser* DATE *May 31* 19 *34*

19. UNDERTAKER *Wackerfeldt* (ADDRESS) *2331 Broadway*

20. FILED *11 31* 19 *34* *J. Brebeck* Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *May 28* 19 *34*

22. I HEREBY CERTIFY, That I attended deceased from *May 28* 19 *34* to *May 28* 19 *34*

I last saw him alive on *May 28* 19 *34* Death is said

to have occurred on the date stated above, at *11:30 p.m.*

The principal cause of death and related causes of importance were as follows:

*Erysipela, Facial*  
*Bronchopneumonia*  
*Chronic Myocarditis*

Other contributory causes of importance

Name of operation

What test confirmed diagnosis? *Clinical* Date of ..... there an autopsy? *No*

23. If death was due to external causes (wound), fill in also the following:

Accident, suicide, or homicide? *No* Date of injury ..... 19 .....

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify *No*

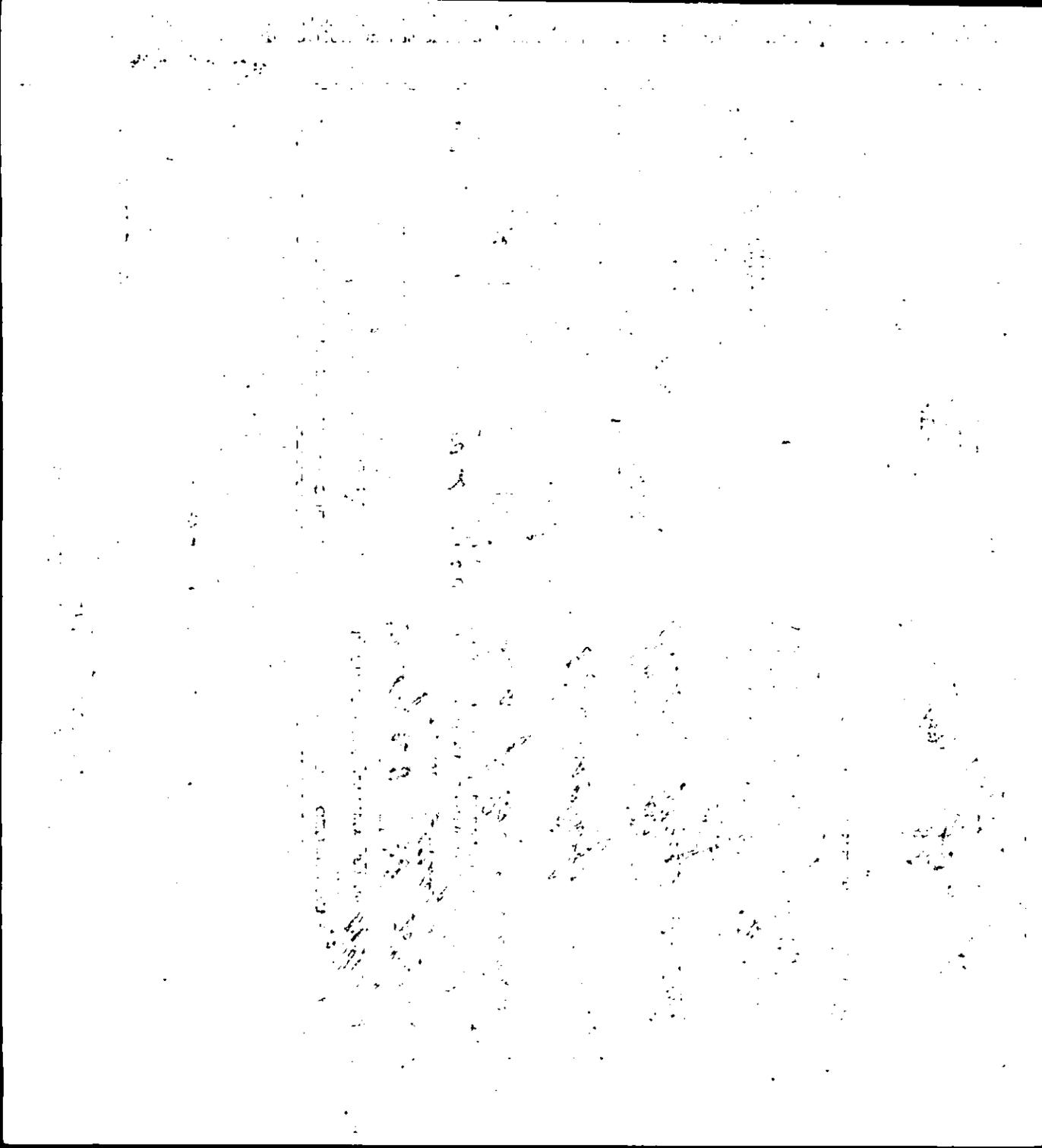
(Signed) *John E. Leubrenner* M. D.

(Address) *ISOLATION HOSPITAL*

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.

JUN 19 1934

31 22



*St Louis City*

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: *Gus Eschelback*

Who died at *Walton Hosp* on *May 28 - 1934*

Residence: No. \_\_\_\_\_ St. \_\_\_\_\_  
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_

Sex *m* Color or race *W* Single, married, widowed or divorced: \_\_\_\_\_

Date of birth \_\_\_\_\_ Age: Years *73* Months \_\_\_\_\_ Days \_\_\_\_\_

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month \_\_\_\_\_ Year \_\_\_\_\_

Birthplace (State or country) *Broncho pneumonia*

Birthplace of father (State or country) \_\_\_\_\_

Birthplace of mother (State or country) *Crypelus - facial*

Principal cause of death: \_\_\_\_\_

*950*

Other contributory causes of importance \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19 \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

Name of physician \_\_\_\_\_

Address of physician \_\_\_\_\_

Signature of Registrar *Jot Bredick 4-15-34*

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

*E. T. Mc Gaugh M.D.*  
*g.e.*

Reg. Dist. No. 791

Primary Reg. Dist. No. 1003

Special Agent.

1934  
S-18878