

Registration District No. **791**

Primary Registration District No. _____

Registrar's No. **5385**

1. PLACE OF DEATH: **1008**

(a) County **St. Louis**

(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **4549a Laclede Ave.** **2**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community _____

3. (a) PRINT FULL NAME **Barbara Eschbacher**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **F.** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **M.**

6. (b) Name of husband or wife **Arthur J.** 6. (c) Age of husband or wife if alive **42** years

7. Birth date of deceased **Dec. 29, 1897**
(Month) (Day) (Year)

8. AGE: Years **41** Months **5** Days **16** If less than one day _____ hr. _____ min.

9. Birthplace **Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **At Home**

11. Industry or business

MOTHER FATHER { 12. Name **Unk. Lekar**

{ 13. Birthplace **Unknown**

{ 14. Maiden name **Unknown** (State or foreign country)

{ 15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Arthur J. Eschbacher**

(b) Address **4549a Laclede Ave.**

17. (a) **Calvary Burial** Date thereof **6-19-39**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary**

18. (a) Signature of funeral director **Arthur J. Donnelly**
3840 Lindell Blvd.

(b) **JUN 17 1939**

19. (a) **JUN 17 1939** (Date received local registrar)

(b) **John Budick** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County _____

(c) City or town **St. Louis** **19**
(If outside city or town limits, write "RURAL")

(d) Street No. **4549a Laclede Ave.**
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **16**
year **1939** hour **5** minute **a.** M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death **Purpuric adenocarcinoma of pyloric end of stomach with obstruction and haemorrhage**

Duration _____

Due to _____

Other conditions **Haemorrhage**
(Include pregnancy within 3 months of death)

PHYSICIAN _____

Major findings: **H. B.**

Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically X

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify name of place)

23. Signature **John M. Quinn** (M. B. or other) **4**

Address **Deputy Coroner** Date signed **6/16**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 6-17-39

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.

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed W H Van Matre

Licensed Embalmer No. 2825

P. O. Address 3840 Lindell

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 this body is not embalmed, above space should be left blank.