4 1939

DEPARTMENT OF COMMERCE
REG'D BUREAU OF THE CENSUS
REC'D SEP 7 1939

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30186

Registration District No. 784 Primary Registration District No. 107 Registrar's No. 1443

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1. PLACE OF DEATH:

(a) County St. Louis 2

(b) City or town Ladue (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 9243 Clayton Road (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis 1

(c) City or town Ladue (If outside city or town limits, write "RURAL")

(d) Street No. 9243 Clayton Road (If rural, give location)

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

3. (a) PRINT FULL NAME Agnes R. Eckelkamp 242

3. (b) If veteran, name war

3. (c) Social Security No. None

4. Sex F.

5. Color or race W.

6. (a) Single, widowed, married, divorced M.

6. (b) Name of husband or wife Jos. Eckelkamp

6. (c) Age of husband or wife if alive 83 years

7. Birth date of deceased Unk. (Month) Unk. (Day) 1860 (Year)

8. AGE: Years 79 Months Unk. Days Unk. If less than one day hr. min.

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

10. Usual occupation At Home

11. Industry or business

FATHER
12. Name Michael Ryan
13. Birthplace (City, town, or county) Ireland (State or foreign country)

MOTHER
14. Maiden name Bridget Farrington
15. Birthplace (City, town, or county) Ireland (State or foreign country)

16. (a) Informant's own signature Joseph Eckelkamp

(b) Address 9243 Clayton Road

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-15-1939 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Lindell Blvd.

19. (a) AUG 14 1939 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 12 year 1939 hour 10 minute 30 p. M.

21. I hereby certify that I attended the deceased from July 1, 1933 to Aug 12, 1939; that I last saw her alive on Aug 12 1939; and that death occurred on the date and hour stated above.

Immediate cause of death Senility, Hypostatic Pneumonia

Due to Fracture of Rt Hip

Due to

Other conditions (Include pregnancy within 3 months of death) 1860

Major findings: Of operations None

Of autopsy None

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

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

(a) Accident, suicide, or homicide (specify) Fall, Fracture Rt Hip

(b) Date of occurrence Aug 8

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

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)

While at work? No (e) Means of injury

23. Signature [illegible] (M. D. or other)

Address 4125 Bartmer Ave Date signed

(Licensed Embalmer's Statement on Reverse Side) St Louis Mo

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.....Alfred J. Boedeker

Licensed Embalmer No.....2663

P. O. Address.....4204 Prairie

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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