

No. 2
1-5-43
5-17-39
I X36871

FILED **SEP 20 1946**

State File No. _____
Registrar's No. **6798**

Registration District No. _____ Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
3840 Cleveland Av.
(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

3. (a) PRINT FULL NAME Kate Eckhoff

3. (b) If veteran, name war no 3. (c) Social Security No. 770

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced widow

6. (b) Name of husband or wife Gustav J. Eckhoff 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb 21 1868
(Month) (Day) (Year)

8. AGE: Years 78 Months 5 Days 11 If less than one day _____ hr. _____ min.

9. Birthplace Illinois _____
(City, town, or county) (State or foreign country)

10. Usual occupation At home

MOTHER FATHER

11. Industry or business _____

12. Name John Sparks _____

13. Birthplace Germany _____
(City, town, or county) (State or foreign country)

14. Maiden name Unknown _____

15. Birthplace Germany _____
(City, town, or county) (State or foreign country)

16. (a) Informant Henry Eckhoff
 (b) Address 3840 Cleveland Av.

17. (a) Burial (b) Date thereof 8-5-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Burial Pt. With Bro. & Co.

18. (a) Signature of funeral director J. F. Bredeek
 (b) Address 2929 S. Jefferson Av.

19. (a) AUG 3 1946 (b) Registrar's signature _____
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 3840 Cleveland Av.
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 2nd
 year 1946 hour 5 minute 55 P. M.

21. I hereby certify that I attended the deceased from 1945
 _____, 19____, to Aug 2, 1946
 that I last saw her alive on Aug 2, 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion Duration 10 hours

Due to Senility & Hypertension _____

Due to _____

Other conditions none
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: Of operations none

Of autopsy none

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) none

(b) Date of occurrence _____

(c) Where did injury occur? none
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? none

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Preston C. Hill (M. D. or other M.D.)
 Address 3902 Lafayette Date signed 8/2/46

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

27453

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.....
D. M. Davis

Licensed Embalmer No. *3741*

P. O. Address *2929 Jefferson*

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, fact should be so stated above.