

S. No. 2  
M-8-43  
3-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **6226**

**FILED FEB 17 1947**  
Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **1320**

**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:  
ST. JOHNS HOSP 0  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution HOSP 11 DAYS  
 (Specify whether  
 In this community 70 YRS  
 years, months or days)

**3. (a) PRINT FULL NAME** CHARA EICKMEYER

3. (b) If veteran, name war NIL

3. (c) Social Security No. NONE

4. Sex F 5. Color or race W

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

6. (b) Name of husband or wife HERMAN EICKMEYER

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

7. Birth date of deceased NOV 9 1876  
 (Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>70</u>	<u>2</u>	<u>28</u>	.....hr. ....min.

9. Birthplace ST. LOUIS MO  
 (City, town, or county) (State of foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business NIL

**MOTHER FATHER**

12. Name AUGUST THIELE

13. Birthplace UNK GERMANY  
 (City, town, or county) (State of foreign country)

14. Maiden name MARY OBERMEIER

15. Birthplace CINC. OHIO  
 (City, town, or county) (State of foreign country)

16. (a) Informant BERNARD THIELE

(b) Address 4001 N. FLORISSANT AVE

17. (a) BURIAL (b) Date thereof 2/10/46  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: CALVARY CEM

18. (a) Signature of funeral director W. E. Meyer

(b) Address 3924 N. 29 ST

19. (a) FEB 8 1947  
 (Date received local registrar)

J. F. Budeck  
 (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MO (b) County 22000  
17

(c) City or town ST. LOUIS  
 (If outside city or town limits, write "RURAL") 9

(d) Street No. 2621 HICKORY ST  
 (If rural, give location) 0

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country.....

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Feb day 7  
 year 1947 hour 11 minute A M.

21. I hereby certify that I attended the deceased from Feb 6, 1947, to Feb 7, 1947,  
 that I last saw her alive on Feb 6, 1947,  
 and that death occurred on the date and hour stated above.

Immediate cause of death Acute pyelitis Duration 48 hrs

Due to Chronic pyelonephritis 4 mos  
Non-calculous

Due to.....

Other conditions (Include pregnancy within 3 months of death) 113

Major findings:  
 Of operations.....

Of autopsy.....

**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).....

(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?.....

(Specify type of place)  
 While at work John King (c) Means of injury MI

23. Signature John King (M. D. or other) MI

Address 671 E. Bay Bend Rd Date signed.....

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

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**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..... A. A. Smithers.....

Licensed Embalmer No. 3916.....

P. O. Address. 3934 N. 20 St.....

**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.**