

FILED JUN 17 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22001
State File No. 5125

1003

BIRTH NO. _____ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. _____ Registrar's No. _____

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony Hospital		d. STREET ADDRESS (If rural, give location) 5854 Delor St.	
3. NAME OF DECEASED (Type or Print) a. (First) Emil b. (Middle) Charles c. (Last) Seckel		4. DATE OF DEATH (Month) (Day) (Year) June 10 1950	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 2, 1870
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Grocer	9. AGE (In years last birthday) 79
11. BIRTHPLACE (State or foreign country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U S A	
13a. FATHER'S NAME George Seckel		13b. MOTHER'S MAIDEN NAME Katherine Huth	14. NAME OF HUSBAND OR WIFE Clara Quinlan Seckel
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Clara Quinlan Seckel 5854 Delor St.
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc.: It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary disease ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary infarct	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 7 mo.	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR 4201	
22. I hereby certify that I attended the deceased from 11/7/1949 to 6/10/1950, that I last saw the deceased alive on 6/9/1950, and that death occurred at 2:45 P.M., from the causes and on the date stated above.			
23a. SIGNATURE W. F. Heun MD (Degree or title)		23b. ADDRESS 2203 Chippewa	23c. DATE SIGNED 6/11/50
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE June 13, 1950	24c. NAME OF CEMETERY OR CREMATORY St. Trinity Cemetery	24d. LOCATION (City, town, or county) (State) Lemay, Mo.
DATE REC'D BY LOCAL REG. JUN 12 1950	REGISTRAR'S SIGNATURE J. B. Foster	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. Hoffmeister Colonial Mortuary 6464 Chippewa St.	

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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Harry J. Schumacher* _____

Licensed Embalmer No. *2679* _____

P. O. Address *7814 F. Broadway* _____

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.