

STANDARD CERTIFICATE OF DEATH

24525

State File No.

8-7-51

318

1003

6260

BIRTH FILED AUG 7 1951 REG. DIST. NO. 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 Illinois b. COUNTY St. Clair	
b. CITY OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Granite City 8120	
c. LENGTH OF STAY (in this place) 5 WKS.		d. STREET ADDRESS (If rural, give location) 1746 Edison 8	
d. FULL NAME OF HOSPITAL OR INSTITUTION Alexian Bro. Hosp.			

3. NAME OF DECEASED (Type or Print) a. (First) MANDEL b. (Middle) c. (Last) EICHLER		4. DATE OF DEATH (Month) (Day) (Year) July 27, 1951	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH UNK
9. AGE (in years last birthday) 46 69		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail merchant	11. BIRTHPLACE (State or foreign country) Austria Hungary 8
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail merchant		10b. KIND OF BUSINESS OR INDUSTRY Grocery	12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Mandel Eichler		13b. MOTHER'S MAIDEN NAME Gitel UNK		14. NAME OF HUSBAND OR WIFE Daisy	
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. None		17. INFORMANT'S SIGNATURE AND ADDRESS Mrs. Daisy Eichler 1746 Edison	

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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Dissecting aneurysm of abdominal aorta b.		INTERVAL BETWEEN ONSET AND DEATH instant
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arterio-sclerosis DUE TO (c) High blood-pressure		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma of Bladder nephritis		

19a. DATE OF OPERATION June 20-51		19b. MAJOR FINDINGS OF OPERATION Bladder tumor		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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? 187X	

22. I hereby certify that I attended the deceased from June 5, 1951, to July 22, 1951, that I last saw the deceased alive on July 22, 1951, and that death occurred at 5:35 p.m., from the causes and on the date stated above.

23a. SIGNATURE Elmer E. Dalton (Degree or title)		23b. ADDRESS 918 Olive St. St. Louis 1		23c. DATE SIGNED July 28-51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 7/29/51		24c. NAME OF CEMETERY OR CREMATORY Chesed Shel meth	
24d. LOCATION (City, town, or county) (State) University City Mo.					

DATE REC'D BY LOCAL REG. JUL 28 1951		REGISTRAR'S SIGNATURE J. B. Jarator		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Berger Memorial 4715 McPherson	
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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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed *James A. Rudolph*.....

Licensed Embalmer No. *4339*.....

P. O. Address.....

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.