

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6370

State File No.

WED MAR 5 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1416**

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	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 16 3510 Miami St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Mamie b. (Middle) c. (Last) Eschrich			4. DATE OF DEATH (Month) (Day) (Year) 2/13/52			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Feb. 20, 1883	9. AGE (In years last birthday) 68	IF UNDER 1 YEAR Months Days	IF UNDER 1 MIN. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Jacob Deottling		13b. MOTHER'S MAIDEN NAME Mamie Gebhardt		14. NAME OF HUSBAND OR WIFE William	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Frieda Eschrich-3510 Miami	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) Carcinoma of the stomach DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>		INTERVAL BETWEEN ONSET AND DEATH ? ?	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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? 157X	

22. I hereby certify that I attended the deceased from **Feb. 7, 1952**, to **Feb. 13, 1952**, that I last saw the deceased alive on **Feb. 13, 1952** and that death occurred at **7:00p m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Clarence E. Miller M.D.		23b. ADDRESS 634 N. Grand Blvd.		23c. DATE SIGNED 2-14-52	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2/15/52		24c. NAME OF CEMETERY OR CREMATORY St. Pauls Churchyard	
		24d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri			

DATE REC'D BY LOCAL REG FEB 14 1952		REGISTRAR'S SIGNATURE Carl Smith, MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wacker-Helderle 3634 Gravois	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

Licensed Embalmer No. _____

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.