

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **2734**
0178
Registrar's No. _____

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|--|--|-------------------------------|-------------------|---|--|--|--|--|--|------------------------------|--|---|--|------------------------------|--|--------------------------------|--|--|--|--|--|--|--|----------------------------------|--|--|--|
| BIRTH NO. _____ | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. NO. 1003 | | State File No. 2734 | | 0178 | | | | | | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY _____ | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY _____ | | | | | | | | | | | | | | | | | | | | | | | |
| b. CITY (If outside corporate limits, write RURAL and give town or town) St Louis | | | | c. LENGTH OF STAY (in this place) 25 yrs | | c. CITY (If outside corporate limits, write RURAL and give township) St Louis | | | | | | | | | | | | | | | | | | | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 4431 Rosa | | | | d. STREET ADDRESS 4431 Rosa | | 2029 0 | | | | | | | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Henry | | | b. (Middle) _____ | | | c. (Last) Eck | | | 4. DATE OF DEATH (Month) Jan (Day) 6 (Year) 1954 | | | | | | | | | | | | | | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | | 8. DATE OF BIRTH Dec. 14, 1881 | | 9. AGE (in years last birthday) 72 | | # UNDER 1 YEAR Days _____ | | # UNDER 10 Hrs. Hours _____ | | # UNDER 1 MIN. Min. _____ | | | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | | | 10b. KIND OF BUSINESS OR INDUSTRY Butcher | | | | 11. BIRTHPLACE (City and State or Foreign Country) St Louis Mo. | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | | | | | | | | |
| 13a. FATHER'S NAME Eck | | | | 13b. MOTHER'S MAIDEN NAME not known | | | | 14. NAME OF HUSBAND OR WIFE Amelia Eck | | | | | | | | | | | | | | | | | | | |
| 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 OR NAME Amelia Eck | | | | ADDRESS 4431 Rosa | | | | | | | | | | | | | | | |
| 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. | | | | | | | | | | | | MEDICAL CERTIFICATION | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic myocarditis | | | | | | | | | | | | Diabetes Mellitus | | | | | | | | | | | | 3 yrs 7 mos | | | |
| ANTECEDENT CAUSES | | | | | | | | | | | | DUE TO (b) Chronic Nephritis | | | | | | | | | | | | 3 yrs 7 mos | | | |
| Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | | | | | | | | | | | DUE TO (c) None | | | | | | | | | | | | 3 yrs 7 mos | | | |
| II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. None | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION None | | | | 19b. MAJOR FINDINGS OF OPERATION None | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | |
| 21a. ACCIDENT SUICIDE HOMICIDE No. | | | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None | | | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) None | | | | | | | | | | | | | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) None m. | | | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21f. HOW DID INJURY OCCUR? None 592x | | | | | | | | | | | | | | | | | | | |
| 22. I hereby certify that I attended the deceased from 5-22 , 18 50 , to 1-5 , 18 54 , that I last saw the deceased alive on 1-5 , 18 54 , and that death occurred at 3:20A m., from the causes and on the date stated above. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. SIGNATURE (Degree or title) J. Harry G. Heidenreich MD | | | | | | | | | | | | 23b. ADDRESS 3750 Gravois | | | | 23c. DATE SIGNED 1-6-54 | | | | | | | | | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 24b. DATE 1/9/54 | | | | 24c. NAME OF CEMETERY OR CREMATORY N. St. Marcus Cemetery | | | | 24d. LOCATION (City, town, or county) (State) St Louis Mo. | | | | | | | | | | | | | | | |
| DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE J. Carl Smith MD | | | | 25. FUNERAL DIRECTOR'S SIGNATURE L Ziegenhein & Sons | | | | ADDRESS 7027 Gravois | | | | | | | | | | | | | | | | | | | |
| JAN 8 1954 | | | | REG. DIST. NO. 318 | | | | (Licensed Embalmer's Statement on Reverse Side) | | | | | | | | | | | | | | | | | | | |

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 *Neville B. Frohwitter*

Licensed Embalmer No. *3696*

P. O. Address *7027 Garvie*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.