

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 1108  
Registrar's No.

BIRTH NO. FILED MAR 4 1954 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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 Mo. 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) 5 days		d. STREET ADDRESS (If rural, give location) 15 3111 1/2 Osceola	
d. FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hosp.			

3. NAME OF DECEASED (Type or Print) a. (First) Bernard b. (Middle) J c. (Last) Eckrich			4. DATE OF DEATH (Month) (Day) (Year) 2 3 54		
5. SEX M W M W		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	
8. DATE OF BIRTH 7/19/04		9. AGE (In years last birthday) 49		10. KIND OF BUSINESS OR INDUSTRY Gaylord Box	
11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo.		12. CITIZEN OF WHAT COUNTRY? USA			

13a. FATHER'S NAME Martin Eckrich		13b. MOTHER'S MAIDEN NAME Lena Johnson		14. NAME OF HUSBAND OR WIFE Florence Eckrich	
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.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Florence Eckrich 3111 Osceola	

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction  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.		INTERVAL BETWEEN ONSET AND DEATH 8 days	
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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 4201	

22. I hereby certify that I attended the deceased from Jan 30, 1954, to Feb 3, 1954, that I last saw the deceased alive on Feb 3, 1954, and that death occurred at 10:30 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Edward W. Czuchra M.D.		23b. ADDRESS 3701 Grand St		23c. DATE SIGNED 2/16/54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 2/16/54		24c. NAME OF CEMETERY OR CREMATORY Resurrection	
24d. LOCATION (City, town, or county) St. Louis Co. Mo					

DATE REC'D BY LOCAL REG. FEB 4 1954		REGISTRAR'S SIGNATURE J. Earl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS SCHUMACHER FUNERAL HOME, INC. 3013 meram	
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(Licensed Embalmer's Statement on Reverse Side)

**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

*Jack Haupt*

Licensed Embalmer No.

4741

P. O. Address

St. Paul's 9

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.