

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **5897**

FILED FEB 21 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **310** PRIMARY REG. DIST. NO. **3058** Registrar's No. **55**

1. PLACE OF DEATH a. COUNTY <b>St. Charles</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Warren</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Charles</b>		c. CITY OR TOWN <b>Wright City</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (In this place) <b>5 Wks</b>		e. STREET ADDRESS (If rural, give location) <b>Route 1, Box 30</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Joseph Hospital</b>		1090	

3. NAME OF DECEASED (Type or Print) a. (First) <b>EUGENE</b> b. (Middle) <b>HENRY</b> c. (Last) <b>RECKAMP</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Feb. 16, 1955</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Jan. 4, 1899</b>	9. AGE (In years last birthday) <b>56</b>	IF UNDER 1 YEAR: Months <b>0</b> Days <b>12</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>

13a. FATHER'S NAME <b>Charles Reckamp</b>	13b. MOTHER'S MAIDEN NAME <b>Elizabeth Heckenkamp</b>	14. NAME OF HUSBAND OR WIFE <b>Evelyn Behlmann Reckamp</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs Evelyn Reckamp, Wright City, Mo.</b>

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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of stomach</b>		<b>3.6 hrs.</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Carcinomatous pectorae</b> DUE TO (c)		<b>2 mo.</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>151 X</b>			

19a. DATE OF OPERATION <b>Jan 20, 1955</b>	19b. MAJOR FINDINGS OF OPERATION <b>Extensive carcinoma of stomach pancreas liver</b>	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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Nov 6, 1954**, to **Feb 16, 1955**, that I last saw the deceased alive on **Feb 16, 1955**, and that death occurred at **6:43 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Gusell Glider M.D.</b>	23b. ADDRESS <b>St Charles, Mo</b>	23c. DATE SIGNED <b>Feb 17 1955</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>2-18-55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cemetery Florissant, Mo.</b>
24d. LOCATION (City, town, or county) (State)	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>White Chapel Funeral Home, St. Charles, Missouri</b>	
DATE REC'D BY LOCAL REG. <b>Feb. 17-1955</b>	REGISTRAR'S SIGNATURE <b>Frankie Hammett</b>	

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

FEB 24 1954

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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.....  
Signature of Student Embalmer

Signed *E. Euan Province*.....

Licensed Embalmer No. 3403..

P. O. Address Jennings, Ill.

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.