

Health, Welfare Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED SEP 5 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29392

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1923

1. PLACE OF DEATH a. COUNTY <b>St. Louis,</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Madison</b>			
b. CITY (If outside corporate limits, give-TOWNSHIP only) OR TOWN <b>Clayton, Mo.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Alton</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) - HOSPITAL OR INSTITUTION <b>Enroute County Hosp. DOA</b>				Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <b>1511 Central</b>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>J.</b> Last <b>Eckhard</b>			4. DATE OF DEATH Month <b>Aug.</b> Day <b>9,</b> Year <b>1956</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 6, 1884</b>		9. AGE (In years last birthday) <b>71</b> IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman Electric</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Appliance Co.</b>		11. BIRTHPLACE (City and state or country) <b>Alton, Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Charles Eckhard</b>				14. MOTHER'S MAIDEN NAME <b>Josephine Votteroot</b>			
15. WAS DECEASED EVER IN U. S. ARMY FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>Nil.</b>		17. INFORMANT <b>Mrs. Lucille Sears, Alton, Ill.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple fracturing, extensive</b> <b>brain damage and hemorrhage</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Struck by car while walking from the south to the north side of Highway 66</b>				
20c. TIME OF INJURY Hour <b>6:00</b> Month <b>8/9/56</b> Day <b>8/9/56</b> Year <b>56</b> Mm. <b>PM</b> p. m. <b>PM</b>							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>highway</b>		20f. CITY, TOWN, OR LOCATION <b>rural</b>		COUNTY <b>St. Louis</b> STATE <b>Mo.</b>	
21. I attended the deceased from _____ to _____ and last saw her him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>Ernest J. Williams</b> (Degree or title)			22b. ADDRESS <b>Clayton, Mo.</b>			22c. DATE SIGNED <b>8/13/56</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>8-13-56</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Josephs Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Alton, Illinois,</b>		
24. FUNERAL DIRECTOR <b>Albert H. Hoppe</b> ADDRESS <b>4700 Washington,</b>				25. DATE RECD. BY LOCAL REG. <b>8-10-56</b>		26. REGISTRAR'S SIGNATURE <b>Herbert R. Dowling</b>	

(Licensed Embalmer's Statement on Reverse Side)

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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 *Stanley H. Day*.....

Licensed Embalmer No. *41*.....

P. O. Address *St. L.*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.