

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36626

STATE FILE NUMBER

FILED OCT 24 1956

Registration District No. 312 Primary Registration District No. 500 Registrar's No. 2323

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LEMAY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Lemay</u> <u>H870</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>409 JETT</u>			Length of stay in 1b <u>7 YRS</u>	d. STREET ADDRESS (If outside, give location) <u>409 Jett</u>			Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Howard L. Eichhorn</u>				4. DATE OF DEATH <u>OCTOBER 1 1956</u>		Month Day Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 7, 1920</u>	9. AGE (In years last birthday) <u>36</u>	IF UNDER 1 YEAR	IF UNDER 24 HRS.
						Months	Days
						Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Special Adjust Man</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Laclede Gas Co.</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Eichhorn</u>				14. MOTHER'S MAIDEN NAME <u>Myrtle Jameison</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes WW-2</u>		16. SOCIAL SECURITY NO. <u>498-09-7726</u>		17. INFORMANT Address <u>Mrs. Margaret Eichhorn 409 Jett ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malignant melanoma</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	DUE TO (c)					
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 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.)				
20c. TIME OF INJURY	Hour	Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE
21. I attended the deceased from <u>6/27/49</u> to <u>10/1/56</u> and last saw her/him alive on <u>9/26/56</u> Death occurred at <u>1:15 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>H. W. Eades M.D.</u>				22b. ADDRESS <u>7602 So. Broadway</u>		22c. DATE SIGNED <u>10/1/56</u>	
23a. BURIAL, CREMATION, or other (Specify) <u>Burial</u>	23b. DATE <u>Oct. 4, 1956</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>3700 Mt. Olive Road Lemay 23, Miss</u>			
24. FUNERAL DIRECTOR <u>C. HOFFMEISTER U.I.C.</u> ADDRESS <u>7814 S. BROADWAY</u>			25. DATE RECD. BY LOCAL REG. <u>10-2-56</u>		26. REGISTRAR'S SIGNATURE <u>Herbert R. Dombek</u>		

diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Use only black ink or ribbon typewriter if possible.

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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 *Bill C. Brand* .....

Licensed Embalmer No. *47* .....

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.