

FILED JAN 13 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

45790

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **12367**

S. 300
v. 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 casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 05 Bethesda Hospital		Length of stay in lb -	d. STREET ADDRESS (If outside, give location) 149 STREET ADDRESS 5433 Lindenwood
3. NAME OF DECEASED (Type or print) First Otto Middle H. Last Eschenbrenner		4. DATE OF DEATH Month 12 Day 22 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. - 1879
9. AGE (In years last birthday) 78		IF UNDER 1 YEAR Months 7 Days 1 Hours 1 Min.	IF UNDER 24 HRS. Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Station Attendant		10b. KIND OF BUSINESS OR INDUSTRY Filling Station	11. BIRTHPLACE (City and state or country) Cannelton, Indiana
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Daniel Eschenbrenner	
14. MOTHER'S MAIDEN NAME Louisa Rabe		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 Address Alvin Eschenbrenner, 4117 Oregon	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adeno Carcinoma of Hypopharynx + metastasis to the lungs			INTERVAL BETWEEN ONSET AND DEATH 1 year
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypopharynx + metastasis to the lungs DUE TO (c) to the lungs			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
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.) 147x		
20c. TIME OF INJURY Hour . Month, Day, Year a. m. p. m.			
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 12/10/56 to 12/22/57 and last saw him alive on 12/22/57 Death occurred at 2:35 P.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Malcolm B. Howell M.D.		22b. ADDRESS 2600 Newland Ave	22c. DATE SIGNED 12/24/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12/26/57	23c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
24. FUNERAL DIRECTOR ADDRESS Drehmann-Harral 1905 Union Blvd.		25. DATE RECD. BY LOCAL REG. DEC 24 57	26. REGISTRAR'S SIGNATURE J. Pearl Smith, M.D.

Dr. Maccolm C. Bawell
4660 Maryland Ave.
Hrs. Noon Tuesday

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 *Warren A. Carver*

Licensed Embalmer No. 353

P. O. Address

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.