

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011818
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 857

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>ST LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SAPPINGTON</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>SAPPINGTON 4840</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF DECEASED (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>11038A GRAVOIS</u>		Length of stay in lb <u>6 YRS</u>	d. STREET ADDRESS (If outside, give location) <u>11038A GRAVOIS</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>FRED</u> Middle <u>H</u> Last <u>EICHORST</u>			4. DATE OF DEATH Month <u>MAR.</u> Day <u>28</u> Year <u>1959</u>		
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5. SEX <u>MALE</u> <u>0</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>JUNE 13, 1892</u>	9. AGE (In years, months, days) <u>66</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during 12 months before death or if retired) <u>HEAT COOPER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>HEAT COOPER</u>	11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>AUGUST EICHORST</u>	13b. MOTHER'S MAIDEN NAME <u>AUGUSTA MICHALSKI</u>	14. NAME OF HUSBAND OR WIFE <u>EMMA EICHORST</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <u>no</u> unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>493-05-1804A</u>	17. INFORMANT <u>EMMA EICHORST</u> Address <u>11038A GRAVOIS</u>
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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>Carcinoma of lung</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</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.) <u>16 3x</u>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>GRAVOIS</u>	COUNTY <u>ST LOUIS</u>	STATE <u>MO.</u>
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20d. INJURY OCCURRED WHILE AT <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 <u>GRAVOIS</u>	COUNTY <u>ST LOUIS</u>	STATE <u>MO.</u>
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21. I attended the deceased from <u>Jan 27, 1959</u> to <u>March 28, 1959</u> and last saw him alive on <u>March 28, 1959</u> Death occurred at <u>7:40 p</u> m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Charles Silverberg, M.D.</u>	22b. ADDRESS <u>9901 Gravois Ave.</u>	22c. DATE SIGNED <u>March 30, 1959</u>
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23a. BURIAL, CREMATION, REPOSING (Specify)	23b. DATE <u>3/31/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LAKEWOOD PARK</u>	23d. LOCATION (City, town, or county) (State) <u>ST LOUIS COUNTY MO.</u>
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24. FUNERAL DIRECTOR <u>JOHN L ZIEGENHEIN & SONS 7027 GRAVOIS</u>	25. DATE RECD. BY LOCAL REG. <u>3-30-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

300
1-57

FILED APR 6 1959

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 *B. P. K.*

Licensed Embalmer No.

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.**