

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036685

FILED VS NOV 12 1959

STATE FILE NUMBER

Registration District No. 162 Primary Registration District No. 5594 Registrar's No. 106

1. PLACE OF DEATH a. COUNTY <b>Jefferson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Jefferson</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>House Springs</b>		Length of stay in 1b		c. CITY OR TOWN <b>House Springs</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>Box 158 Route #1</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Box 158 Route #1</b>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>AUGUST</b> Middle <b>ELCHINGER</b> Last <b>ELCHINGER</b>				4. DATE OF DEATH Month <b>Oct</b> Day <b>27</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>12-22-1872 86</b>	9. AGE (last birthday) <b>86</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Beer Bottler</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Busch Brewery</b>		11. BIRTHPLACE (City and state or country) <b>St Louis Mo</b>		12. CITIZEN OF WHAT COUNTRY <b>U S A</b>
13a. FATHER'S NAME <b>George Elchinger</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Anna Elchinger</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>488-07-1837</b>		17. INFORMANT <b>Walter Eckerle</b> Address <b>House Springs, Mo</b>			
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>metastatic carcinoma generalized</b> DUE TO (b) <b>Carcinoma of liver</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							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) <b>malnutrition</b>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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 _____ a.m. _____ p.m. 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 <b>June 59</b> to <b>26 Oct 59</b> and last saw her alive on <b>26 Oct 59</b> Death occurred at <b>12 10 a</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>H. Muttler MD</b>				22b. ADDRESS <b>Rickwood mo</b>		22c. DATE SIGNED <b>28 Oct 59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Oct 29, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New St Marcus Cem</b>		23d. LOCATION (City, town, or county) (State) <b>St Louis Mo</b>			
24. FUNERAL DIRECTOR <b>Thomas Kutis</b> ADDRESS <b>2906 Gravois</b>			25. DATE RECD. BY LOCAL REG. <b>10-29-59</b>		26. REGISTRAR'S SIGNATURE <b>Robert E. Bauer</b>		

10-29-59

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DOCUMENT

BY AFFIDAVIT OF Registrar

MEDICAL CERTIFICATION

NOV 19 1956 SA

NOV 20 1956

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

*Eleana Province*

Licensed Embalmer No. 3403

P. O. Address 2906 Gra

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.