

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-013613

FILED VS. MAR 30 1960 317

Primary Registration District No. 547 Registrar's No. 1011

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Richmond Heights		Length of stay in 1b HRS.	c. CITY OR TOWN University City
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Saint Mary's Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 7038 Lindell Ave.
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) JOHN FRANCIS Eschen			4. DATE OF DEATH Month March Day 25 Year 1960			
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5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/30/1909	9. AGE (last birthday) 50	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Director of KSD Radio Stat.	10b. KIND OF BUSINESS OR INDUSTRY Radio	11. BIRTHPLACE (City and state or country) Hannibal, Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME John H. Eschen	13b. MOTHER'S MAIDEN NAME Frances E.C. WHITE	14. NAME OF HUSBAND OR WIFE Helen B. Eschen
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) World War II	16. SOCIAL SECURITY NO. 494-09-9478	17. INFORMANT Address Mrs. Helen Eschen 7038 Lindell Ave.
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) My accidental suffocation		1 week
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Company Oxy. thrombosis of vein	
	DUE TO (c) Heart. Atherosclerosis	1 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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.)
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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 checked="" 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
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21. I attended the deceased from 3-16-51 to 3-25-60 and last saw him alive on 3-25-60 Death occurred at 303 R.W. on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) James P. [Signature]	22b. ADDRESS 634 N. Grand Blvd	22c. DATE SIGNED 3-26-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE March 28, 1960	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Missouri
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24. FUNERAL DIRECTOR ADDRESS Arthur J. Donnelly 3840 Lindell Blvd.	25. DATE RECD. BY LOCAL REG. 3-26-60	26. REGISTRAR'S SIGNATURE [Signature]
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DR. JAMES MURPHY
MISSOURI THEATRE BUILD.

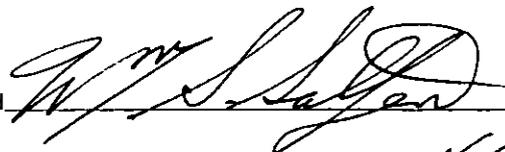
JUN 21 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed



Licensed Embalmer No. 4699

P. O. Address 3840 Lind

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.