

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9593 - 61-038502 STATE FILE NUMBER

FILED OCT 26 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		a. STATE <u>MISSOURI</u> b. COUNTY <u>JEFFERSON</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		c. CITY OR TOWN	
Length of stay in lb		d. STREET ADDRESS (If outside, give location)	
<u>ST LOUIS</u>		<u>ARNOLD</u>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
<u>ALEXIAN BROS HOSPITAL</u>		<u>RT 4 - Box 427</u>	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First	Middle	Last	Month	Day	Year
<u>ORVILLE</u>	<u>ELROY</u>	<u>ECKER</u>	<u>OCT</u>	<u>16</u>	<u>1961</u>
5. SEX	6. COLOR OR RACE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR IF UNDER 24 HR
<u>MALE</u>	<u>WHITE</u>		<u>JULY-18-1921</u>	<u>40</u>	Months <u>2</u> Days <u>29</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)	
<u>TRUCK DRIVER</u>		<u>VON DER HAAR SAND GRAVEL</u>		<u>MO.</u>	
12. CITIZEN OF WHAT COUNTRY		<u>U.S.A.</u>			
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE	
<u>HENRY ECKER</u>		<u>HELEN BOCKENHOLT</u>		<u>BETTE ECKER</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
<u>No</u>		<u>NIL</u>		<u>BETTE ECKER</u>	
Address <u>RT 4 - Box 427</u>		Address <u>ARNOLD MO</u>			
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) <u>v Brain Brain Hemorrhage</u>					<u>48 hrs.</u>
DUE TO (b) <u>Metastatic Carcinoma to Brain</u>					<u>2 wks ?</u>
DUE TO (c) <u>Bronchogenic Carcinoma (left)</u>					<u>20 months</u>
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"/> N. <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 s.m. p.m. Month, Day, Year		<u>1621</u>			
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 May 1947, to October 16, 61 and last saw him <sup>alive</sup> on 10/15/61  
Death occurred at 12:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u> (Degree or title)	22b. ADDRESS <u>7430 Virginia Avenue</u>	22c. DATE SIGNED <u>10/16/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county)
<u>REMOVAL</u>	<u>OCT-19-1961</u>	<u>MT HOPE CEM.</u>	<u>LEMAY, MO</u>

24. FUNERAL DIRECTOR <u>FEV FUNERAL HOME MEHLVILLE MO</u>	25. DATE RECD. BY LOCAL REG. <u>OCT 17 1961</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

**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 *J. A. P. [Signature]*

Licensed Embalmer No. 4329

: P. O. Address *St. Louis Mo*

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.