

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-007996

STATE FILE NUMBER

AMENDED

Registration District No. 18 Primary Registration District No. 1003 Registrar's No. 2031

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>1 month</u>		c. CITY OR TOWN <u>Florissant</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>De Paul Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3925 Parker Rd.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>Bell</u> Last <u>Lyon EICKMANN</u>				4. DATE OF DEATH Month <u>February</u> Day <u>18</u> Year <u>1962</u>					
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>12-10-1890</u>	9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Nelson Fillmore Lyon</u>			13b. MOTHER'S MAIDEN NAME <u>Martha Bell Sexton</u>			14. NAME OF HUSBAND OR WIFE <u>Henry Joseph Eickmann</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Florissant, Mo.</u> <u>Mr. Richard B. Miller, 1440 Paddock Dr.</u>				
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 Head of Pancreas</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) _____						
			DUE TO (c) _____					<u>157 X</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 checked="" 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 <u>Jan. 1959</u> to <u>Feb. 1962</u> and last saw her alive on <u>18 Feb. 1962</u> Death occurred at _____ <u>11 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>R. J. Cannon, M.D.</u> (Degree or title)				22b. ADDRESS <u>Florissant Mo.</u>				22c. DATE SIGNED <u>2-19-62</u>	
23a. BURIAL, CREMATION, REINTERMENT (Specify) <u>Burial</u>		23b. DATE <u>2-20-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine Cemetery</u>			23d. LOCATION (City, town, or county) <u>St. Louis</u>		(State)	
24. FUNERAL DIRECTOR ADDRESS <u>Alexander & Sons, 6175 Delmar Blvd.</u>				25. DATE RECD. BY LOCAL REG. <u>FEB 19 1962</u>		26. REGISTRAR'S SIGNATURE <u>Leon Smith, M.D.</u>			

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT BY AFFIDAVIT OF

MEDICAL CERTIFICATION

Dr. Robert J. O'Conner
751 S. Frances
Florissant, Mo.
Phone: TE 7-3568

JAN 24 1964

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 Joseph M. Conlon

Licensed Embalmer No. 2461

P. O. Address 6402 W. 11th

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.