

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-020356

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5539**

FILED JUN 27 1962 78891

VS 300
Rev. 4/59

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DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b 50 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY		c. CITY OR TOWN NORMANDY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION VAH, 915 N. GRAND AVE.				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) 8714 WELDON				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES E. ECKHOFF						4. DATE OF DEATH Month Day Year 5/31/62					
5. SEX MALE		6. COLOR OR RACE WHITE		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 9/18/87		9. AGE (last birthday) 74		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED BRASS PLATER				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country) ST. LOUIS, MISSOURI		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME CHARLES E. ECKHOFF				13b. MOTHER'S MAIDEN NAME MEALIE VEPOL				14. NAME OF HUSBAND OR WIFE EMMA ECKHOFF			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-I				16. SOCIAL SECURITY NO.		17. INFORMANT Address EMMA ECKHOFF (WIDOW) SEE #2					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE										INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (b) PNEUMONIA AND PULMONARY EMBOLI											
DUE TO (c) LEFT THROMBOPHLEBITIS AND POLYCYTHEMIA											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) CHOLECYSTITIS, CHOLEDOCHOLITHIASIS 464x								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 checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/>		20b. 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 4/11/62 to 5/31/62 and last saw him alive on 5/31/62 . Death occurred at 10:10 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) A. J. FRCSKEY, M.D.						22b. ADDRESS VAH, ST. LOUIS, MO.				22c. DATE SIGNED 5/31/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 6/4/62		23c. NAME OF CEMETERY OR CREMATORY St Paul Churchyard		23d. LOCATION (City, town, or county) (State) St Louis County Mo					
24. FUNERAL DIRECTOR ADDRESS Moydell Funeral Home 1926 Allen						DATE RECD. BY LOCAL REG. JUN 2 1962		25. REGISTRAR'S SIGNATURE W. A. Smith, M.D.			

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 Harley E. Jaellke Jr
Licensed Embalmer No. 4950
P.O. Address St. Louis

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.