

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space

23418

1. PLACE OF DEATH

County Laurens Registration District No. 467
 Township Aurora Primary Registration District No. 4280
 City Aurora (No. 103 west Lyndall) St. _____ Ward _____

File No. _____
 Registered No. 215

2. FULL NAME Clair Gene Ekhoff

(a) Residence. No. 103 w Lyndall St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 9 - 1928

7. AGE	YEARS	MONTHS	DAY	If LESS than 1 day, _____ hrs. or _____ min.
	<u>2</u>	<u>5</u>	<u>1</u>	

B. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work _____
- (b) General nature of industry, business, or establishment in which employed (or employer) _____
- (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Aurora
 (STATE OR COUNTRY) Mo.

10. NAME OF FATHER J. F. Ekhoff

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Okla

12. MAIDEN NAME OF MOTHER Oliver Boyers

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Aurora
 (STATE OR COUNTRY) Mo.

14. INFORMANT J. F. Ekhoff
 (Address) Aurora Mo

15. FILED Aug 8, 1930 R. W. Smart
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July - 10 1930

17. I HEREBY CERTIFY, That I attended deceased from July 8, 1930, to July 10, 1930 that I last saw him alive on July 9, 1930 and that death occurred, on the date stated above, at 1:45 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Streptococcus Hemolyticus
infection

18. WHERE WAS DISEASE CONTRAICTED _____
 IF NOT AT PLACE OF DEATH _____

CONTRIBUTORY (SECONDARY) Staphylococcus aureus
 _____ (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRAICTED _____
 IF NOT AT PLACE OF DEATH _____

18. WHERE WAS DISEASE CONTRAICTED _____
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Staph and Strep
 (Signed) R. W. Smart M. D.

19 (Address) Aurora Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

Maple Park Cemetery 1930

20. UNDERTAKER King Funeral Home ADDRESS Aurora

N. B.—Every item of information should be carefully supplied. Ages should be stated exactly. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

AUG 20 1930

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Lawrence Registration District No. 467 File No.
Township Primary Registration District No. 4280 Registered No.
City Amoria (No.) St. Ward)

2. FULL NAME

Clair Gene Ekhoff

(a) Residence, No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

S

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, hrs.
or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT

(Address)

15.

FILED August 19-30

August 8-30

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

July 10 1930

17.

I HEREBY CERTIFY, That I attended deceased from
to, 19.....

that I last saw him alive on, 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

King August 11 1930
King Funeral Co

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. Every health information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

SUPPLEMENTARY

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