

REC'D MAY 18 1939

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

14504

Do not use this space.

1. PLACE OF DEATH

(a) County Carroll Registration District No. 138
(b) Township Egypt Primary Registration District No. 4078 Registered No. 8
(c) City Norborne (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

251 Sophia Katherine Eschenbach
(a) Residence, No. Norborne mo. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 23, 1865

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
73 7 2

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) Jan., 1939 11. Total time (years) spent in this occupation 53 yrs

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Leibensstadt Baden, Germany13. NAME John Kugler14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Leibensstadt Baden, Germany15. MAIDEN NAME Marie Kolb16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Leibensstadt Baden, Germany17. INFORMANT (ADDRESS) Mrs. Chas. Buchholz Norborne, Mo.18. BURIAL, CREMATION, OR REMOVAL PLACE Fairhaven DATE 4-27 193919. FUNERAL DIRECTOR (ADDRESS) W. T. Stroud Norborne, Mo.20. FILED 4-27-39 B. C. Cole Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr. 25, 193922. I HEREBY CERTIFY, That I attended deceased from 2-14, 1939, to 4-24, 1939I last saw h or alive on April 24, 1939. Death is said to have occurred on the date stated above, at 7 a. m.
The principal cause of death and related causes of importance were as follows:Pneumonia Bronchial Date of onset 4-17-39Other contributory causes of importance: gangrene left elbowName of operation none Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
Nature of injury _____24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____(Signed) C. J. ... M. D.(Address) Norborne Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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

1072

RECEIVED
District Health Officer No. 8,
District File Number
Filed 6/3/39

STATEMENT BY LICENSED EMBALMER

I, J. P. Stouck Licensed Embalmer No. 2406

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

..... L. E.

No. or by Registered Apprentice No.
working under my personal supervision.

Signed J. P. Stouck
Licensed Embalmer No. 2406

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.)

RECEIVED

614

1 X1334

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

14504
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1. PLACE OF DEATH

(a) County Carroll Registration District No. 138
 (b) Township _____ Primary Registration District No. 4078 Registered No. _____
 (c) City Norborne (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Sophia Katherine Eschenbach
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Wed
(write the word)

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.
73 7 2

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19____

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED _____ 19____

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 25 1939

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____

I last saw h. _____ alive on _____, 19____. Death is said

to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Pneumonia Bronchial Date of onset 1330

Other contributory causes of importance:

Fracture left Elbow caused by hypodermic injection of for kidney block

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) Eugene L. Bales, M. D.

(Address) Norborne

WRITE PLAINLY IN BLUE INK ON BOTH SIDES OF PERMANENT RECORD

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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW

SUPPLEMENTARY

