

FILED APR 18 1940

Registration District No. 2957

Primary Registration District No. 51374053

Registrar's No. 87

1. PLACE OF DEATH:

(a) County Butler
(b) City or town Harrisville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 7
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 mo. (Specify whether years, months or days)
In this community 6 mo.

8. (a) PRINT FULL NAME Eda May Eckhardt
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex female 5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Geo. J. Eckhardt 6. (c) Age of husband or wife if alive 62 years
7. Birth (date of deceased) Dec. 24 1879 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>60</u>	<u>3</u>	<u>19</u>	hr. min.

9. Birthplace Paris (City, town, or county) Ill. (State or foreign country)

10. Usual occupation housewife

11. Industry or business _____

MOTHER, FATHER
12. Name Ernie Overstreet
13. Birthplace Unknown Ky (9) (City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature E. J. Eckhardt
(b) Address Harrisville
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof April 15-40 (Month) (Day) (Year)
(c) Place: burial or cremation Kansas

18. (a) Signature of funeral director Minnie Hill
(b) Address Naylor, Mo.
19. (a) 4/15-40 (Date received local registrar) (b) Olalutsinger (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Butler
(c) City or town Harwell (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 14th year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from March 1st, 1940 to April 14, 1940 that I last saw her alive on April 14, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Circosis of Liver.

Due to _____
Due to _____

Other conditions Fracture of pelvis (Include pregnancy within 3 months of death)

Major findings: Of operations X
Of autopsy X

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) X
(b) Date of occurrence X
(c) Where did injury occur? X (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? X

23. Signature E. J. Eckhardt (M. D. or other) X
Address Harwell, Mo. (Specify type of place) (e) Means of injury X
Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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 important.

1442-
99

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed A. C. McCord

Licensed Embalmer No. 4079

P. O. Address Naylor, 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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10308

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 87

Primary Registration District No. 4053

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Butler

(b) City or town Marwell
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Dr. May Eckhardt

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex 7 5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years 60 Months 3 Days 18

If less than one day _____ hr. _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

{ 13. Birthplace _____
(City, town, or county) (State or foreign country)

{ 14. Maiden name _____

{ 15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(If outside city or town limits write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years

20. DATE OF DEATH: Month Apr day 14
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that I last saw h. _____ alive on _____ 19____;
and that death occurred on the date and hour stated above
Immediate cause of death Cerebrosis of liver Duration _____

Due to _____

Due to _____

Other conditions: Fracture of Pelvis
(Include pregnancy within 3 months of death)

Major findings: Accident in St. Louis
Of operations: in 1937

Of autopsy: Treated in City Hospital
Never able to walk without crutch

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature F. F. Farr (M. D. or other) _____

Address Fredericksburg Date signed _____

SUPPLEMENTARY

S-10308.

1940