

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28471
Registrar's No. 26

Registration District No. 305

Primary Registration District No. 4184

1. PLACE OF DEATH:

(a) County GASCONADE
(b) City or town OWENSVILLE
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: OWENSVILLE 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 4 MONTHS
years, months or days)

3. (a) PRINT FULL NAME WILLIAM CHESLEY EOFF 150
8. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife MILLIE MAY EOFF 6. (c) Age of husband or wife if alive DEAD years
7. Birth date of deceased APRIL 5 1858
(Month) (Day) (Year)

8. AGE: Years 82 Months 4 Days 23 If less than one day
hr. _____ min. _____

9. Birthplace RICHWOOD, Mo G
(City, town, or county) (State or foreign country)

10. Usual occupation LABORER

11. Industry or business

MOTHER FATHER { 12. Name ✓ EOFF
13. Birthplace NOT KNOWN 9
(City, town, or county) (State or foreign country)
14. Maiden name NOT KNOWN
15. Birthplace NOT KNOWN 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Cora Rose
(b) Address Owensville, Mo.

17. (a) BURIAL (b) Date thereof AUG 31 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation FEFF C.E.M. HARMAND HEIGHTS

18. (a) Signature of funeral director W.F. Gattenbacher

(b) Address Owensville, Mo.

19. (a) 8-30-40 (b) Dr. J. J. Banner MD
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County GASCONADE
(c) City or town MARYLAND HEIGHTS, Mo.
(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 AUGUST day 28
year 1940 hour 9 minute 30 P.M.

21. I hereby certify that I attended the deceased from August 19
_____ 1940, to Aug. 28, 1940
that I last saw him alive on Aug. 28, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Hemiplegia-right 9 days
Duration

Due to Cerebral Hemorrhage 9 days

Due to Hypertension 10 years

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations.

Of autopsy

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? 928
(Specify type of place) While at work (e) Means of injury: _____

23. Signature Paul A. Brenner (M. D. or other) MD
Address Owensville, Mo. Date signed 8-30-40

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

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 Mrs

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

Signed.....

Milford H. H. Winter

Licensed Embalmer No. 3838

P. O. Address Quincyville 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.