

Registration District No. 219 Primary Registration District No. 5301 Registrar's No. _____

1. PLACE OF DEATH:
(a) County Cooper
(b) City or town Palestine Township
(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)
In this community Life years, months or days

3. (a) PRINT FULL NAME A. Hoke Eichelberger
3. (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 Sarah Elizabeth 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec 14 1859
(Month) (Day) (Year)

8. AGE: Years 81 Months 3 Days 4 If less than one day hr. _____ min. _____

9. Birthplace Cooper Co. MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Farm

MOTHER FATHER { 12. Name Andrew E Eichelberger
13. Birthplace Virginia
(City, town, or county) (State or foreign country)
14. Maiden name Belle Kaiser
15. Birthplace Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant Hall Eichelberger
(b) Address Boonville, Mo.

17. (a) Burial (b) Date thereof 3 20 41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Pilot Grove Cem.

18. (a) Signature of funeral director Goodman Y. Miller
(b) Address Boonville, Mo.

19. (a) 3-18-41 (b) Ann Whitaker
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Cooper 27
(c) City or town Rural 0
(If outside city or town limits, write "RURAL")
(d) Street No. Palestine Township 0
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 18th year 1941 hour 8 minute 15 A.M.
21. I hereby certify that I attended the deceased from Mar 16 1941 to Mar 18 1941; that I last saw him alive on Mar 17 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Thrombia Duration 6 weeks

Due to _____
Due to _____

Other conditions Pneumonia 3 days
(Include pregnancy within 3 months of death) terminal PHYSICIAN _____

Major findings: _____
Of operations _____
Of autopsy _____
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? _____

23. Signature Jackson H. Wells (M. D. or other) MD.
Address Boonville, Mo. Date signed Mar 18 1941

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

7
0
0

10
12
17

FILED MAY 7 1941

104

RECEIVED
KOMEIWA HIOCC
MAY 14 1941

RECEIVED
District Health Officer No. 8,
File Number
5-6-41

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 G. F. Boller

Licensed Embalmer No. 3062

P. O. Address Boonville, 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 14368

Registration District No. 219

Primary Registration District No. 6301

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Copier
 (b) City or town Palatine T.P.
(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 _____)
 In this community _____
years, months or days

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) Citizen of foreign country _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME A Hoke Eichelberger
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Mar day 8
 year 1941 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

4. Sex m 5. Color or race w
 6. (a) Single, widowed, married, divorced wid
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ year _____ month _____ day _____
 7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

Immediate cause of death _____
 Due to _____
 Due to _____
 Other conditions (include pregnancy within 3 months of death) _____
 Duration _____

8. AGE: Years 81 Months 3 Days 4
 If less than one day _____ hr. _____ min.

Due to _____
 Due to _____
 Other conditions (include pregnancy within 3 months of death) _____
 Due to _____

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

10. Usual occupation _____

11. Industry or business _____

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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

Physician's findings:
 Of operations none
 Of autopsy none
 Underline the cause to which death should be charged statistically.
Solar Pneumonia Terminal

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)
 (e) Means of injury _____
 23. Signature Hubert H. Wells (M. D. or other) _____
 Address 108 _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

S-14360