

Registration District No. **213**

Primary Registration District No. **3014**

Registrar's No. **269**

1. PLACE OF DEATH:

(a) County. Cole  
 (b) City or town. Jefferson City, Mo.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: St. Mary's Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 30 hours  
 In this community 30 hours (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State. Mo (b) County. Orange  
 (c) City or town. Loose Creek  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. Rt # 1  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME ANNA LOUISE EICKHOFF

3. (b) If veteran, name war. \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife. \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept 17 1941  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
6 hr. min.

9. Birthplace Loose Creek Mo  
 (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Leo Eickhoff  
 13. Birthplace Loose Creek  
 (City, town, or county) (State or foreign country)

14. Maiden name Olivia Deschellen  
 15. Birthplace Loose Creek Mo  
 (City, town, or county) (State or foreign country)

16. (a) Informant Leo Eickhoff  
 (b) Address Loose Creek

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Loose Creek

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 9-18-41 (b) Norma Richter  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 18  
 year 1941 hour 6:00 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from Sept 17, 1941 to Sept 18, 1941,  
 that I last saw her alive on Sept 18, 1941,  
 and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity

Due to 6 mos 3 weeks

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 J. A. Cushman (M. D. or other)

Address Jefferson City Date signed 9-18-41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

2  
39  
9  
1492

11-11-41

/Di

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**

2B  
21-41  
K29288

Registration District No. 213

Primary Registration District No. 3014

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Cole  
(b) City or town Jefferson City  
(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.....  
In this community.....  
years, months or days) (Specify whether

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 Anna L. Eickhoff

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced.....

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased Sept 17 1941  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day min.

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

10. Usual occupation.....  
11. Industry of 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) Burial (b) Date thereof unknown  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....  
(b) Address.....

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day.....  
year 1941 hour..... minute..... M.

21. I hereby certify that I attended the deceased from.....  
19.....  
that I last saw him..... live on..... 19.....  
and that death occurred on the date and hour stated above.  
Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....

Of autopsy.....

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?  
.....  
(Specify type of place)

While at work?..... (e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-31398 1941