

FILED OCT 16 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

32327

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County PUTNAM
 (b) City or town UNIONVILLE, MO.
 (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 _____ years, months or days

3. (a) PRINT FULL NAME

CHLOETTE ANN ECKLES

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 S B

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

7. Birth date of deceased May 14 1938
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
3 2 24 hr. min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Clarence
 13. Birthplace MO
 (City, town, or county) (State or foreign country)
 14. Maiden name Liane
 15. Birthplace MO
 (City, town, or county) (State or foreign country)

16. (a) Informant Clarence(b) Address Unionville, MO

17. (a) Burial (b) Date thereof Aug-8-41
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Unionville MO18. (a) Signature of funeral director [Signature](b) Address Unionville, MO

19. (a) Sept 4 (b) [Signature]
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Putnam
 (c) City or town Unionville
 (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.? ✓ 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 7
 year 1941 hour 12 minute 50 A. M.

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

Immediate cause of death Cancer of faceDue to Do not know

Due to _____

Other conditions
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations 53

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 E H Mayee (M. D. or other) PAddress Unionville MO Date signed 8/8/41

(Licensed Embalmer's Statement on Reverse Side)

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

23159

6
1
0

086

0

Duration

year

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 10

District File Number 10-41-1768

Date Filed OCT 8 1941

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 M. E. Aurdid
Licensed Embalmer No. 3504
P. O. Address Monroville

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. 32327

Registration District No. 718

Primary Registration District No. 6430

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Putnam
(b) City or town Unionville
(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 _____
years, months or days)

3. (a) PRINT FULL NAME Charlette A. Eckles
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 S

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

7. Birth date of deceased May 14, 1928
(Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

12. Name Clarence Wm Eckles

13. Birthplace Adair Co. Mo
(City, town, or county) (State or foreign country)

14. Maiden name Lucille Strains

15. Birthplace Putnam Co. Mo
(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) Apr 4, 1941 (b) N. W. Gillman
(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr Day _____
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.
Immediate cause of death _____

Duration

Due to _____

Due to _____

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? _____

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

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

Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER, FATHER

