

FILLED NOV 14 1941

Registration District No. 85

Primary Registration District No. 1001

Registrar's No. 1637

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1811 S. 10th Street.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None
(Specify whether
In this community Lifetime
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 1811 S. 10th St.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME John Henry Eckhardt

3. (b) If veteran. name war None 3. (c) Social Security No. 491-10-2149

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Emma Eckhardt 6. (c) Age of husband or wife if alive 65 years
7. Birth date of deceased December 3 1882
(Month) (Day) (Year)

8. AGE: Years 58 Months 10 Days 4 If less than one day
.....hr.min.

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

10. Usual occupation Retired Cigar maker, also with Western Grocery Co.

11. Industry or business _____

12. Name Julius Eckhardt

13. Birthplace Unknown Austria
(City, town, or county) (State or foreign country)

14. Maiden name Magdalena Miller

15. Birthplace Unknown Bavaria
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Emma Eckhardt

(b) Address 1811 S. 10th St. St. Joseph, Mo.

17. (a) BURIAL (b) Date thereof Oct 9, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ASHLAND CEM. Buchanan St. Joseph, Mo.

18. (a) Signature of funeral director Wm. J. Neff
(b) Address 1802 Union Str. St. Joseph, Mo.

19. (a) 10-8-1941 (b) H. G. Neff
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 7
year 1941 hour 7 minute 00 P.M.

21. I hereby certify that I attended the deceased from July 17, 1941, to Oct. 6, 1941
that I last saw him alive on Oct. 6, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to Hypertension
chronic suppurative
Due to bronchitis

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

Major findings: g3a
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) (c) Means of injury _____

23. Signature Wm. J. Neff (M. D. or other) D. O.
Address 123 Larson Date signed 10-7-41

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

MOTHER FATHER

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 Robert C. Harrington
Licensed Embalmer No. 3258
P. O. Address St. Joseph, 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.