

BUREAU OF THE CENSUS
FILED APR 11 1945

State File No. _____

Registration District No. 116

Primary Registration District No. 30210

Registrar's No. 28

1. PLACE OF DEATH:

(a) County Franklin
(b) City or town Washington Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1 Busset Catalpa Ave
(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 1 1/2 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Franklin
(c) City or town Washington Mo
(If outside city or town limits, write "RURAL")
(d) Street No. Catalpa Ave
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME GOFTLOB JOHN ECKSTEIN

3. (b) If veteran, name war none 3. (c) Social Security No. none

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

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

7. Birth date of deceased July 21 1865
(Month) (Day) (Year)

8. AGE: Years 78 Months 7 Days 18 If less than one day hr. _____ min. _____

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

10. Usual occupation Retired Farmer

11. Industry or business _____

12. Name John George Eckstein

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

14. Maiden name not known

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

16. (a) Informant Arthur Eckstein

(b) Address Washington Mo.

17. (a) Burial (b) Date thereof 3-12-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Port Hudson

18. (a) Signature of funeral director Otto

(b) Address Washington Mo.

19. (a) 3-11-44 (b) Flucellhuetten Brook
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 9
year 1944 hour 5 PM minute 02 M.

21. I hereby certify that I attended the deceased from 2 27
1944 to 3 - 9
that I last saw him alive on Mar 9 and that death occurred on the date and hour stated above.

Immediate cause of death: of epilepsy

Due to: Hypostatic Pneumonia

Due to: arterial hypertension

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

Major findings: None

Of operations _____

Of autopsy No

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(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 _____

Signature W. J. Goodrich (M. D. or other)

Address Washington Mo Date signed 3-11-44

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

662

1181

RECEIVED

District Health Officer No. 9,

District File Number _____

Date Filed 4-5-44

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 _____

M. Otto

Registered Apprentice No. _____

working under my personal supervision.

Signed _____

M. Otto

Licensed Embalmer No. 2464

P. O. Address Washington 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.