

FILED DEC 8 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37683

Registration District No. 117

Primary Registration District No. 5428

Registrar's No. 89

1. PLACE OF DEATH:

(a) County Franklin
(b) City or town Rural Boone Twp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Rosebud, Mo. Route 1.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 1
(Specify whether)
In this community 39 years.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin 36
(c) City or town Rural 0
(If outside city or town limits, write "RURAL")
(d) Street No. Rosebud Route 1
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country. 0

3. (a) PRINT FULL NAME FRED WILLIAM EICHOFF

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 married
6. (c) Age of husband or wife if alive 54 years
7. Birth date of deceased September 26 1874
(Month) (Day) (Year)

8. AGE: Years 70 Months 1 Days 29
If less than one day
hr. - min. -

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

10. Usual occupation Farming

11. Industry or business

12. Name William Eichoff
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Catherine Braden
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Fred Eichoff
(b) Address Rosebud, Mo. Route 1.

17. (a) Burial (b) Date thereof 11 27 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Warren Cemetery
18. (a) Signature of funeral director Welford H. H. White
(b) Address Osborneville, Mo.
19. (a) 11-27-44 (b) Don Owens
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 25
year 1944 hour 1 minute 40 A.M.

21. I hereby certify that I attended the deceased from June, 1944 to NOV 25, 1944
that I last saw him alive on Nov 24, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Post-Encephalitis
Duration 2 yrs

Due to 80%

Due to
Other conditions (include pregnancy within 3 months of death)
Major findings: Of operations None
Of autopsy None

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?

(Specify type of place)
While at work? (a) Means of injury
23. Signature Charles A. Schmidt (M. D. or other)
Address Geneva Mo Date signed 11-26-44

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

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 12-6-44

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 Me

....., Registered Apprentice No.....

working under my personal supervision.

Signed Melford A. H. Kenter

Licensed Embalmer No. 3838

P. O. Address Owensville 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.