

S. No. 2  
OM-2-43  
v. 5-17-39  
-1 X35897

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **9580**

**FILED APR 13 1945**  
Registration District No. **113**

Primary Registration District No. **5430**

Registrar's No. ....

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

1. PLACE OF DEATH:

(a) County **Franklin**

(b) City or town **Central Township**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **1**  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Franklin**

(c) City or town **Central Township**  
(If outside city or town limits, write "RURAL")

(d) Street No.....  
(If rural, give location)

(e) Citizen of foreign country?.....**1** (Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME **George Eckstein**

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **15**  
year **1945** hour **2** minute **30p.** M.

4. Sex **Male 1** 5. Color or race **White** 6. (a) Single, widowed, married, divorced. **Single**

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

7. Birth date of deceased **Feb. 1863**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **3-15** to **3-15**, 19**45**, that I last saw him alive on **3-14**, and that death occurred on the date and hour stated above.

8. AGE: Years **82** Months Days If less than one day  
hr. min.

Immediate cause of death **Serivity**

Due to **Actinobaculosis**

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

10. Usual occupation **Laborer**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations..... **97**

Of autopsy.....

11. Industry or business

12. Name **Unknown**

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

14. Maiden name **Barbara Porst**

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant **Mrs. Miller**  
(b) Address **Neier Mo.**

17. (a) **Burial** (b) Date thereof **3-17-45**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Union, Mo.**

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?.....

18. (a) Signature of funeral director **Union Funeral Home**  
(b) Address **Union, Missouri**

19. (a) **3/22/1945** (b) **D. J. King M.**  
(Date received local registrar) (Registrar's signature)

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

23. Signature **D. J. King** (M. D. or other) **MD**  
Address **Union Mo** Date signed **3-16-45**

1120

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 4-17-45

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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. 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.