S. No. 2
OM—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 23 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 34188

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 281

1. PLACE OF DEATH:

(a) County Marion

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

(c) Name of hospital or institution:
Masonic Temple 117 N. 5th. St. 3
(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 Illinois (b) County Adams 990

(c) City or town Quincy 11
(If outside city or town limits, write "RURAL")

(d) Street No. 1806 Grove Ave. 0
(If rural, give location)

(e) Citizen of foreign country? No. 2 (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Charles Frederick Eichenauer

3. (b) If veteran, name war World War, I.

3. (c) Social Security No. .....

4. Sex Male 0

5. Color or race White

6. (a) Single, ~~widowed, married,~~ ~~divorced~~ Single 0

6. (b) Name of husband or wife None

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

7. Birth date of deceased October 9, 1881
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
63	11	17	..... hr. ..... min.

9. Birthplace Warsaw Ill. 1
(City, town, or county) (State or foreign country)

10. Usual occupation Editor

11. Industry or business Quincy-Herald Whig

FATHER
12. Name Frederick Eichenauer 4
13. Birthplace Walzlar Germany 1
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Elizabeth Goebel
15. Birthplace Germany 4
(City, town, or county) (State or foreign country)

16. (a) Informant John H. Seickman 1
(b) Address 1201 ParkPlace Quincy Ill.

17. (a) Removal (b) Date thereof 26 Sept. 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Mount, Quincy Ill.

18. (a) Signature of funeral director Crawford Smith
(b) Address Hannibal, Mo

19. (a) 9-27-45 (b) Dr. E. M. Lucke
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 26
year 1945 hour 10 minute 10 P. M.

21. I hereby certify that I attended the deceased from Sept 26, 1945 to Sept 26, 1945
that I last saw him alive on dead when I saw him, 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis Sudden

Due to Died Sudden

Due to Arteriosclerosis of Coronary Arteries

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations .....
Of autopsy .....

940

Duration

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? ..... (e) Means of injury .....

23. Signature H B Norton (M. D. or other)

Address Hannibal Mo. Date signed 9-27-45

B44

(Licensed Embalmer's Statement on Reverse Side)

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.

NOT EMBALMED

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.