

FILED NOV 18 1946

Registration District No. _____

Primary Registration District No. 4469

1. PLACE OF DEATH:

(a) County STE. GENEVIEVE
(b) City or town STE. GENEVIEVE
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location) _____
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 4 YEARS years, months or days

3. (a) PRINT FULL NAME JOSEPH F. EICKENHORST

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 WIDOWED

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

7. Birth date of deceased DEC 26 1863
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
82 10 7 _____ hr. _____ min.

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

10. Usual occupation BLACKSMITH

11. Industry or business _____

MOTHER FATHER { 12. Name THEODORA EICKENHORST
13. Birthplace GERMANY 4
(City, town, or county) (State or foreign country)
14. Maiden name UNKNOWN
15. Birthplace GERMANY 4
(City, town, or county) (State or foreign country)

16. (a) Informant Joseph H. Eickenhorst

(b) Address St. Genevieve Mo

17. (a) REMOVED (b) Date thereof 11-6-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation WASHINGTON MO

18. (a) Signature of funeral director Geo C. Spiller

(b) Address St. Genevieve Mo

19. (a) Nov. 7 - 1946 (b) Teresa M. Carl
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County STE. GENEVIEVE
(c) City or town STE. GENEVIEVE
(If outside city or town limits, write "RURAL") _____
(d) Street No. 1009 RIDGWAY
(If rural, give location) _____
(e) Citizen of foreign country? NO (Yes or No) _____
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV day 3
year 1946 hour 8 minute 55 P. M.

21. I hereby certify that I attended the deceased from Oct 3
1946 to Nov 3 1946
that I last saw him alive on Nov 1 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Cardiac Dehydration
Due to Arteriosclerosis 10 yrs
Chronic nephritis 10 yrs
Due to Prostatic Hypertrophy 10 yrs
Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN _____
Major findings: _____
Of operations: _____
Of autopsy: _____
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? _____
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature Aldephorck (M. D. or other) _____
Address St. Genevieve Mo Date signed 11-4-46

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

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 Geo. C. Barber

Licensed Embalmer No. 1985

P. O. Address St. Severine La

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.