

FILED JUN 22 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

BIRTH NO. _____ REG. DIST. NO. 223 PRIMARY REG. DIST. NO. 4474 Registrar's No. 22

97
03

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

1. PLACE OF DEATH a. COUNTY <u>SALINE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>SALINE</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SWEET SPRINGS</u>	c. LENGTH OF STAY (In this place) <u>LIFE</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SWEET SPRING, Mo</u>	3. <u>3</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>104 PATRICK ST</u>		d. STREET ADDRESS (If rural, give location) <u>104 PATRICK ST.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>LOUIS</u> b. (Middle) <u>HENRY</u> c. (Last) <u>ECKHOFF</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>JUNE 15, 1949</u>		
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWER</u>	8. DATE OF BIRTH <u>APR. 6, 1865</u>	9. AGE (In years last birthday) <u>84</u>	10. IF UNDER 1 YEAR Months <u>2</u> Days <u>9</u>	11. IF UNDER 1 HR. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>FILER of SOIL</u>	11. BIRTHPLACE (State or foreign country) <u>SWEET SPRINGS, Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>JOHN ECKHOFF</u>	13b. MOTHER'S MAIDEN NAME <u>ADELBELD BURJEND</u>	14. NAME OF HUSBAND OR WIFE <u>ANNA ECKHOFF</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NONE</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Edw. J. Eckhoff</u>	ADDRESS _____
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>CONGESTIVE HEART FAILURE</u>		INTERVAL BETWEEN ONSET AND DEATH _____
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Senility</u> DUE TO (c) <u>Pyelitis</u>		1 WH
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		1 WH

19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE) <u>Sweet Springs, Saline, Mo</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from Feb 1949 to June 15, 1949, that I last saw the deceased alive on Feb 11, 1949, and that death occurred at 1:48 PM, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Ch. Parsons, M.D.</u>	23b. ADDRESS <u>Sweet Springs, Mo</u>	23c. DATE SIGNED <u>6/17/49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>JUNE 17, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW CEMETERY</u>	24d. LOCATION (City, town, or county) (State) <u>SWEET SPRINGS, Mo</u>
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DATE REC'D BY LOCAL REG. <u>6/17/49</u>	REGISTRAR'S SIGNATURE <u>Dolly Anderson</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>R. C. Carter</u>	ADDRESS <u>Sweet Springs, Mo</u>
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RECEIVED JUN 21

District Health Officer No. 8,

District File Number _____

Date Filed 6-21-49

MAY 13 1952

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed R. C. Carter

Licensed Embalmer No. 35-13

P. O. Address Quint Lopez

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.