

FILED MAY 23 1950

 THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

17694

State File No. _____

BIRTH NO. _____		REG. DIST. NO. <u>274</u>		PRIMARY REG. DIST. NO. <u>3052</u>		Registrar's No. <u>181</u>		
1. PLACE OF DEATH a. COUNTY <u>Pettis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Benton</u>				
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Sedalia</u>)		c. LENGTH OF STAY (In this place township) <u>2 1/2 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Cole Camp</u>		<u>0080</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Bothwell Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>1</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Jacob</u>			b. (Middle) <u>----</u>		c. (Last) <u>Eckhoff</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>12th</u> (Year) <u>1950</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>December 18, 1869</u>	9. AGE (In years last birthday) <u>81</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 48 HRS. Hours _____ Min. _____	
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>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Peter Eckhoff</u>			13b. MOTHER'S MAIDEN NAME <u>Sophia Harms</u>		14. NAME OF HUSBAND OR WIFE <u>Margaret Adeline Eckhoff</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Walter Eckhoff Cole Camp Missouri</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chr. Bright's Disease</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chr. Nephrosiditis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Prostate hypertrophy & retention of urine</u>					INTERVAL BETWEEN ONSET AND DEATH <u>11 1/2 22</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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)				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from <u>May 6</u> , 1950, to <u>May 12</u> , 1950, that I last saw the deceased alive on <u>5-12</u> , 1950, and that death occurred at <u>11:00 p.m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>W. Boyer M.D.</u>				23b. ADDRESS <u>Sedalia Mo</u>		23c. DATE SIGNED <u>5-13-50</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>May 15, 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Cole Camp Memorial</u>		24d. LOCATION (City, town, or county) (State) <u>Cole Camp Mo</u>			
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE <u>W. Campbell</u>			FUNERAL DIRECTOR'S SIGNATURE <u>W. E. Eckhoff</u>		ADDRESS <u>Cole Camp Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300

10-48

RECEIVED MAY 22
District Health Officer No. 8,

District File Number _____

Date Filed 5/22/20

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 E. H. Eichhoff

Licensed Embalmer No. 730

P. O. Address Cole Camp 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.