

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

2133

State File No. ....

FILED JAN 20 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 185 PRIMARY REG. DIST. NO. 5692 Registrar's No. 1

1. PLACE OF DEATH a. COUNTY <u>Linn</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>Rural</u>	c. LENGTH OF STAY (in this place) <u>Life</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>Rural</u> <u>0580</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Parson Creeks Township</u>		d. STREET ADDRESS (If rural, give location) <u>Parson Creeks Township</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>LEE</u>	b. (Middle) <u>ROLAND</u>	c. (Last) <u>ECKERT</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>1-11-53</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>NEVER MARRIED</u>	8. DATE OF BIRTH <u>12-31-46</u>	9. AGE (In years last birthday) <u>6</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>10</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Santa Rosa, Calif</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Karl W. Eckert</u>	13b. MOTHER'S MAIDEN NAME <u>Ethelyn Wilson</u>	14. NAME OF HUSBAND OR WIFE <u>none</u>
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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 <u>Karl W. Eckert, Meadville Mo.</u>	ADDRESS <u>Mo.</u>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>45 min</u> <u>2 yrs</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Status lymphaticus</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cyanosis, Recurrent</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION _____	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>273X</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____	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 Nov 1, 1952, to Jan 11, 1953, that I last saw the deceased alive on Dec 10, 1952, and that death occurred at 10:00 A.M. from the causes and on the date stated above.

23. SIGNATURE <u>Joseph Q. Conrad M.D.</u> (Degree or title)	23b. ADDRESS <u>Chillicothe, Mo</u>	23c. DATE SIGNED <u>Jan 13 53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>1-14-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Edgewood</u>	24d. LOCATION (City, town, or county) (State) <u>Chillicothe, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Jan 13-1953</u>	REGISTRAR'S SIGNATURE <u>Chris G. Marten</u> <u>169-0</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Beulah Funeral Home Leola, Mo</u>	ADDRESS _____
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed *W. R. Wright* \_\_\_\_\_

Licensed Embalmer No. *4655* \_\_\_\_\_

P. O. Address *Sealed off* \_\_\_\_\_

**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.