

All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

57 018054
STATE FILE NUMBER

FILED MAY 20 1957

Registration District No. 231 Primary Registration District No. 3048 Registrar's No. 131

1. PLACE OF DEATH a. COUNTY <u>Nodaway</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Nodaway</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Maryville</u>			Inside Limits Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	c. CITY OR TOWN <u>Skidmore</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Francis Hospital</u>			Length of stay in lb <u>3da.</u>	d. STREET ADDRESS (If outside, give location)			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>BERNICE</u> Middle <u>E</u> Last <u>ECKLES</u>				4. DATE OF DEATH Month <u>5</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-28-1889</u>		9. AGE (In years last birthday) <u>67</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Skidmore, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Eckles</u>				14. MOTHER'S MAIDEN NAME <u>Martha Wiitt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Mrs Donna Eckles, Skidmore, Mo.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bacterial pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchial asthma</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 hrs</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour _____ a. m. _____ p. m.			20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)				
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20f. CITY, TOWN, OR LOCATION		COUNTY		STATE
21. I attended the deceased from <u>3/6/57</u> to <u>5/11/57</u> and last saw her alive on <u>5/11/57</u> Death occurred at <u>2A</u> m on the date stated above; and to the best of my knowledge, from the cause stated.							
22a. SIGNATURE (Degree or title) <u>B. F. Bolt M.D.</u>				22b. ADDRESS <u>Maryville Mo</u>		22c. DATE SIGNED <u>5/14/57</u>	
23a. BURIAL, CREMATION, REBURY (Specify) <u>burial</u>		23b. DATE <u>5/13/1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Graham Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Graham, Mo.</u>	
24. FUNERAL DIRECTOR <u>M. J. Stehman, Maryville Mo</u> ADDRESS			25. DATE RECD. BY LOCAL REG. <u>5-18 57</u>		26. REGISTRAR'S SIGNATURE <u>Bess Bolt</u>		

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.....
Signature of Student Embalmer

Signed *G. M. Melis*

Licensed Embalmer No. *23*

P. O. Address *Maywood*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
(to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.