

## JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-033096

FILED VS OCT 7 1959

STATE FILE NUMBER

Registration District No. 211 Primary Registration District No. 4324 Registrar's No. 38-59

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <b>MILLER</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>TUSCUMBIA, MO.</b>		Length of stay in lb <b>15 Days</b>		c. CITY OR TOWN <b>EUGENE, MO.</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>HUMPHREY HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		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)				4. DATE OF DEATH			
First <b>ANNA</b>		Middle <b>HELEN</b>		Last <b>EIKEN</b>		Month Day Year <b>SEPT. 21, 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11/9/73</b>	9. AGE (last birthday) <b>85</b>	IF UNDER 1 YEAR Month <b>10</b> Day <b>12</b>	IF UNDER 24 HR Hours <b>12</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Taos, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Herman Wakenborg</b>			13b. MOTHER'S MAIDEN NAME <b>Caroline Schneiders</b>		14. NAME OF HUSBAND OR WIFE <b>John Eiken</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Oscar Eiken J C Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>BRONCHIAL PNEUMONIA</b>							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
DUE TO (b) <b>CEREBRAL APOPLEXY</b>						<b>15 DAYS</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)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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 s.m. p.m.		Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>9-6-59</u> to <u>9-21-59</u> and last saw her alive on <u>9-21-59</u> Death occurred at <u>5 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>M. E. Humphrey D.O.</b>				22b. ADDRESS <b>Tuscumbia, Mo.</b>		22c. DATE SIGNED <b>9-23-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9/24/59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>City Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Eldon, Mo.</b>	
24. FUNERAL DIRECTOR <b>Myrtle Smith</b>		ADDRESS <b>J C MO.</b>		25. DATE RECD. BY LOCAL REG. <b>September 25, 1959</b>		26. REGISTRAR'S SIGNATURE <b>Mrs. D. E. Kallenbach</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

6981 12 1959

**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 \_\_\_\_\_  
*Robert H. Miller*

Licensed Embalmer No. 4301  
P. O. Address \_\_\_\_\_  
*Jefferson*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.