

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-016348**

**FILED VS APR 25 1960**

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 161

STATE FILE NUMBER

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, give TOWNSHIP only) OR TOWN <u>Sedalia</u>		Length of stay in it		c. CITY OR TOWN <u>Cole Camp</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Campbell Nursing Home</u> <u>Sedalia, Mo.</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>A.</u> Last <u>Eckhoff</u>				4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1960</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>4-15-1874</u>	9. AGE (last birthday) <u>86</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>5</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Mora, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>United States</u>		
13a. FATHER'S NAME <u>Claus Cordes</u>			13b. MOTHER'S MAIDEN NAME <u>Meta Bohling</u>			14. NAME OF HUSBAND OR WIFE <u>John C. Eckhoff</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Clarence Eckhoff Cole Camp, 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>Cerebrovascular Accident</u> DUE TO (b) <u>Generalized Atherosclerosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Atherosclerotic Heart Disease</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT	SUICIDE	HOMICIDE	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)					
20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>1957</u> to <u>20 April 1960</u> and last saw <u>her</u> alive on <u>8 April 1960</u> Death occurred at <u>9:15 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Donald C. Porter, M.D.</u>					22b. ADDRESS <u>Sedalia, Mo.</u>		22c. DATE SIGNED <u>4/22/60</u>		
23a. BURIAL, CREMATION, OR OTHER FINAL DISPOSITION (Specify) <u>Burial</u>		23b. DATE <u>4-23-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>TRINITY LUTHERAN</u>		23d. LOCATION (City, town, or county) (State) <u>Cole Camp Mo.</u>				
24. FUNERAL DIRECTOR ADDRESS <u>E. L. Eckhoff Cole Camp, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>4-23-1960</u>		26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Charles F. Fox

Licensed Embalmer No. 4610

P. O. Address Roll Camp

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.