

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

LED VS JUL 5 1960

=60-023933

STATE FILE NUMBER

Registration District No. 231 Primary Registration District No. 3048 Registrar's No. 160

INDEXED

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>		Length of stay in 1b <u>10 yrs</u>		c. CITY OR TOWN <u>Maryville</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Francis Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Mount Alverno Convent</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sister Mary Mechtildis Eickholt, O.S.F.</u>			4. DATE OF DEATH Month Day Year <u>June 25 1960</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>2-14-1882</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nursing nun</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Religious</u>		11. BIRTHPLACE (City and state or country) <u>Conception, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Carl Eickholt</u>		13b. MOTHER'S MAIDEN NAME <u>Clementine Giesken</u>		14. NAME OF HUSBAND OR WIFE <u>none</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>Mother M. Vincentia, OSF Maryville, 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>Cerebro-vascular thrombosis</u> DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u> <u>10 yrs</u>	
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 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 Month, Day, Year a.m. p.m.							
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>1957</u> to <u>June 25, 1960</u> and last saw her <u>June 25, 1960</u> Death occurred at <u>11:30 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>[Signature] MD</u>			22b. ADDRESS <u>Maryville Mo</u>			22c. DATE SIGNED <u>6/27/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>6/27/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St Mary's Cemetery</u>		23d. LOCATION (City, town, or county) <u>Maryville Mo.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Atchison Funeral Home, Maryville, Mo</u>			25. DATE RECD. BY LOCAL REG. <u>6-27-60</u>	25. REGISTRAR'S SIGNATURE <u>Bess Ball</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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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 _____
Signature of Student Embalmer

Signed G M Pheasant

Licensed Embalmer No. 2277
P. O. Address Marysville

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.