

Dr. H. Silsby
MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-019711
 STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 794

FILED JUN 3 1963

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY GREENE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Length of stay in lb. 1 YR.	c. CITY OR TOWN SPRINGFIELD Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOHN'S HOSP.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 608 W. WALNUT Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last FRANK WHITSON ECKARD			4. DATE OF DEATH Month Day Year MAY 22 1963
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6/23/89
9. AGE (last birthday) 73		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY FARMER	11. BIRTHPLACE (City, and state or country) WARRENSBURG, MO.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME JOHN ECKARD	
13b. MOTHER'S MAIDEN NAME SARAH ELIZABETH WHITSON		14. NAME OF HUSBAND OR WIFE MRS. AMBIE ECKARD, CHANUTE, KAN.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of ser) NO		17. INFORMANT Address MRS. AMBIE ECKARD, CHANUTE, KAN.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary arterial thrombosis DUE TO (b) Arteriosclerotic vascular disease DUE TO (c) Unknown Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) CVA - old			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 checked="" type="checkbox"/> NO <input 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 a.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 Springfield	COUNTY STATE Greene Mo.
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at 6:30 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE H. H. Lohmeyer (Degree or title) M.D.		22b. ADDRESS 609 Cherry St. Springfield, Missouri.	22c. DATE SIGNED May 24 63
23a. BURIAL CREATION, REMOVAL (Specify) Removal	23b. DATE 5-23-63	23c. NAME OF CEMETERY OR CREMATORY SMITH CEMETERY	23d. LOCATION (City, town, or county) (State) NEAR Alton, Missouri
24. FUNERAL DIRECTOR H. H. LOHMEYER FUNERAL HOME SPRINGFIELD, MO.		25. DATE RECD. BY LOCAL REG. 5-27-1963	26. REGISTRAR'S SIGNATURE Effie G. Melton ew

DO NOT WRITE ON THIS STUB

AMENDED

VS:300
Rev. 4/59

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9331X

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

JUN 4 1963

1963
JUN 4

STATEMENT BY LICENSED EMBALMER

5-24

5-24

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 Lucian T. Swadley

Licensed Embalmer No. 4875

P. O. Address Springfield, Mo.

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.