DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 29987

Registration District No. 875 Primary Registration District No. 6162 Registrar's No. 219

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County: Vernon
(b) ~~City or town~~: Nevada
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hosp # 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 33 yrs 26 days (Specify whether years, months or days)
In this community: Same

2. USUAL RESIDENCE OF DEATHS:
(a) State: Mo (b) County: Cass
(c) City or town: Garden City
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME: Sarah Eshleman

3. (b) If veteran, name war:
3. (c) Social Security No.: None

4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Single
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years

7. Birth date of deceased: July (Month) 11 (Day) 1877 (Year)

8. AGE: Years 63 Months 1 Days 16 If less than one day hr. min.

9. Birthplace: Wayne County (City, town, or county) Ohio (State or foreign country)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Herman Eshleman
13. Birthplace: Pennsylvania (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Amanda Faughner
15. Birthplace: Wayne County (City, town, or county) Ohio (State or foreign country)

16. (a) Informant: Hosp. Recd.
(b) Address: Nevada, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/40 (Month) (Day) (Year)
(c) Place: burial or cremation: Hosp. Cemy

18. (a) Signature of funeral director: Mark Eichinger
(b) Address: Nevada, Mo.

19. (a) 8-28-40 (Date received local registrar) (b) Allen D. Hayes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 27 year 1940 hour 8 minute 15 A. M.

21. I hereby certify that I attended the deceased from Nov. 13, 1938, to Aug 27, 1940, that I last saw h. alive on Aug 27, 1940, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Angio neurotic edema	2 days
Due to: Asthma	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations:
Of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify):
(b) Date of occurrence:
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury:

23. Signature: Wm. J. Crewe M.D. (M. D. or other)
Address: Nevada Date signed 8/27/40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 9-40-1270
Date Filed 9-5-40

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 _____, Registered Apprentice No. _____, working under my personal supervision.

Signed Marshall Eichinger

Licensed Embalmer No. 2656

P. O. Address Nevada, 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 this body is not embalmed, above space should be left blank.