

S. No. 2
M-8-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STANDARD CERTIFICATE OF DEATH

State File No. 1961

FILED FEB 4 1946

Registration District No. 10 Primary Registration District No. 5035 Registrar's No. 13

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

100050

1. PLACE OF DEATH:

(a) County Audrain

(b) City or town Rural Centralia Saline Twp
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
H. #4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days)

3. (a) PRINT FULL NAME Sarah F. Eckley

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex F **5. Color or race** W

6. (b) Name of husband or wife Grant Eckley

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec. 9, 1875
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>70</u>	<u>--</u>	<u>15</u>	hr. _____ min. _____

9. Birthplace Hallsville, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business _____

MOTHER FATHER

12. Name J. F. Triplett

13. Birthplace Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Susan Richardson

15. Birthplace Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Grant Eckley

(b) Address Centralia, Mo.

17. (a) Burial _____ **(b) Date thereof** Dec. 26, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Appleman Chapel

(d) Signature of funeral director Two Amos

(e) Address Mexico, Mo.

19. (a) Jan 10-1946 **(b) Blanche Neely**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Audrain 4

(c) City or town Centralia
(If outside city or town limits, write "RURAL") 0

(d) Street No. R. #4
(If rural, give location) 0

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: month Dec. day 24
year 1946 hour 6 minute 10 A. M.

21. I hereby certify that I attended the deceased from _____
about 2 years to _____, 19____

that I last saw h_____ alive on Dec. 20, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of the lung

Due to Primary in lung

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(c) 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? _____

(e) While at work? _____
(Specify type of place)

(e) Means of injury _____

23. Signature _____ (M. D. or other)

Address Centralia Mo **Date signed** 1/26/46

FEB 11 1946

RECEIVED
District Health Officer No. 10
District File Number 2-46-226
Date Filed FEB 1 1946

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..... *Urs Arnold*

Licensed Embalmer No. *3569*

P. O. Address..... *Mexico*

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, fact should be so stated above.