

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

37001  
STATE FILE NUMBER

FILED DEC 3 1956

Registration District No. 31 Primary Registration District No. 5102 Registrar's No. 23

1. PLACE OF DEATH a. COUNTY <b>BENTON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>BENTON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>EAST WILLIAMS</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <b>EAST WILLIAMS</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>8 MILES WEST OF STOVER</b> Length of stay in lb <b>50 YRS.</b>		d. STREET ADDRESS <b>8 MILES WEST OF STOVER</b> (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARIE KATHERINE ECKHOFF</b> First Middle Last			4. DATE OF DEATH <b>NOV. 22 1956</b> Month Day Year
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 7 1884</b>
9. AGE (In years last birthday) <b>72</b>		IF UNDER 1 YEAR Months <b>4</b> Days <b>15</b> Hours <b>15</b> Min.	IF UNDER 24 HRS. Hours <b>15</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>	11. BIRTHPLACE (City and state or country) <b>MORGAN COUNTY MO</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>FREDERICK SCHAPER</b>	
14. MOTHER'S MAIDEN NAME <b>CATHERINE WEYMUTH</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>GERMAN ECKHOFF</b> Address <b>COLE CAMP MO</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>auricular fibrillation?</b> DUE TO (c) <b>331.X</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>3 mo.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			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 <b>a. m.</b> Month <b>p. m.</b> 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 COUNTY STATE	
21. I attended the deceased from <b>1954</b> to <b>Nov 22, 1956</b> and last saw her/him alive on <b>Nov 21, 1956</b> Death occurred at <b>1:45 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>[Signature]</b> (Degree or title) <b>M.D.</b>		22b. ADDRESS <b>[Address]</b>	
22c. DATE SIGNED <b>11/23/56</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	
23b. DATE <b>NOV. 25 1956</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BOESCHENVILLE</b>	
23d. LOCATION (City, town or county) (State) <b>BENTON COUNTY MO.</b>		24. FUNERAL DIRECTOR <b>J. H. Steverson</b> ADDRESS <b>Stover Mo</b>	
25. DATE RECD. BY LOCAL REG. <b>Nov. 24th 1956</b>		26. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

(Licensed Embalmer's Statement on Reverse Side)

300  
1-56  
 health, Welfare  
Public  
service  
 37001  
 Doctor, coroner, etc., must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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 *J. L. Stevenson*

Licensed Embalmer No. *40*

P. O. Address *Stouck*

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