

**MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS DEC 7 1959 *75*

**59-039395**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. *3015* Registrar's No. *100*

AMENDED

<b>1. PLACE OF DEATH</b> a. COUNTY <i>Clinton</i> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Cameron</i> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Warren Nursing Home</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Clinton</i> c. CITY OR TOWN <i>Cameron</i> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) _____ Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First <i>Eleanor</i> Middle <i>Eickhoff</i> Last _____ <b>4. DATE OF DEATH</b> Month <i>Nov</i> Day <i>26</i> Year <i>1959</i>			<b>5. SEX</b> <i>Female</i> <b>6. COLOR OR RACE</b> <i>White</i> <b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <i>12-11-1872</i> <b>9. AGE</b> (last birthday) <i>86</i> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Housekeeper</i> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>Home</i> <b>11. BIRTHPLACE</b> (City and state of country) <i>Indianapolis, Ind</i> <b>12. CITIZEN OF WHAT COUNTRY</b> <i>USA</i>		<b>13a. FATHER'S NAME</b> <i>Louis Bokanper</i> <b>13b. MOTHER'S MAIDEN NAME</b> <i>Eleanor Roeseher</i> <b>14. NAME OF HUSBAND OR WIFE</b> <i>deceased</i>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____ <b>16. SOCIAL SECURITY NO.</b> _____ <b>17. INFORMANT</b> <i>Mr. William Woodard Osborn</i> Address <i>Mo</i>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Diabetes mellitus</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <i>arteriosclerotic heart disease</i> DUE TO (b) <i>&amp; Decompensation.</i> DUE TO (c) _____ 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		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/> <b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____		<b>20c. TIME OF INJURY</b> Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____		
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ <b>20f. CITY, TOWN, OR LOCATION</b> _____ <b>COUNTY</b> _____ <b>STATE</b> _____		<b>21. I attended the deceased from</b> <i>June 12 - 1955</i> to <i>Nov 26 - 1959</i> and last saw her <i>alive</i> on <i>Nov 26 - 1959</i> Death occurred at <i>1:00 p.m.</i> on the date stated above, and to the best of my knowledge, from the causes stated.		
<b>22a. SIGNATURE</b> (Degree or title) <i>D. Kemer M.D.</i> <b>22b. ADDRESS</b> <i>Cameron Missouri</i> <b>22c. DATE SIGNED</b> <i>11-30-59</i>		<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <i>BURIAL</i> <b>23b. DATE</b> <i>11-30-59</i> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <i>Grace Land Cemetery</i> <b>23d. LOCATION</b> (City, town, or county) (State) <i>CAMERON Mo</i>		
<b>24. FUNERAL DIRECTOR</b> <i>DeMoss CRUNK</i> ADDRESS <i>Cameron, Mo.</i> <b>25. DATE RECD. BY LOCAL REG.</b> <i>11-30-59</i> <b>26. REGISTRAR'S SIGNATURE</b> <i>Francis D Crawford</i>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Re. Mass. Embals

Licensed Embalmer No. 4533

P. O. Address Common. M.

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.