DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25505

FILED AUG 9 1940

Registration District No. 12-0

Primary Registration District No. 3022 5574

Registrar's No. 66

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

1. PLACE OF DEATH:

(a) County: Jefferson

(b) ~~City or town~~ Rural VALLE
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Route 1 Grubville
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution No
In this community 47 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jefferson

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

(d) Street No. Route No. 1 Grubville
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Thomas R. Eoff. 100

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex male

5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Isabelle Davis

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased Nov. 15, (Month) 1868 (Year)

8. AGE: Years 71 Months 7 Days 21 If less than one day ____ hr. ____ min.

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

10. Usual occupation Farming

11. Industry or business

FATHER
12. Name Newton Eoff
13. Birthplace Jefferson Co., (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name ////
15. Birthplace ____ (City, town, or county) ____ (State or foreign country)

16. (a) Informant Roy A Eoff
(b) Address 2427 Walton Rd St Louis

17. (a) burial (Burial, cremation, or removal) (b) Date thereof July 8. 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Bethlehem, R.R. 1, Grubville, Mo.

18. (a) Signature of funeral director Lee Mothershead
(b) Address DeSoto Mo.

19. (a) 8-5-40 (Date received local registrar) (b) Jessie Dowell (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 6
year 1940 hour 12 minute 45 A.M. P.M.

21. I hereby certify that I attended the deceased from July 5, 1940 to July 6, 1940
that I last saw h[illegible] alive on July 5, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Ruptured gall bladder / Duration 2 days

Due to obstruction of the gall duct.

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 Walter E Eoff Jr. (M. D. or other)
Address DeSoto, Mo. Date signed 7/8/40

(Licensed Embalmer's Statement on Reverse Side)

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

Signed Lee Mollenkead

Licensed Embalmer No. 3521

P. O. Address Leslie 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.

DEPARTMENT OF COMMERCE
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STANDARD CERTIFICATE OF DEATH

State File No. 25-505-

Registration District No. 420 Primary Registration District No. 5574 Registrar's No.

1. PLACE OF DEATH:
(a) County Jefferson
(b) City or town Dale (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (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 Thos R. Eoff
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)
8. AGE: Years 71 Months 7 Days 21 If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or ceremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 6
year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.
Immediate cause of death Ruptured gall bladder Duration
Due to Obstruction of the gall duct
Due to Cause of obstruction probably gall stones
Other conditions Stones
(Include pregnancy within 3 months of death)
Major findings:
Of operations 12 6
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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

USE UNFADING BLACK INK—MAKE A PERMANENT RECORD