

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

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17801

1. PLACE OF DEATH
 County Marion Registration District No. 547
 Township Marion Primary Registration District No. 3029
 City Hannibal (No. Surry Hospital) St. _____ Ward _____

2. FULL NAME J. T. Eales
 (a) Residence No. 909 Lindell St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.
 (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)** Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Martha E. Eales

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 19 - 1866

7. AGE: YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
62 4 11

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Employee of Shoe Factory
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Rolls Co. Mo.

10. NAME OF FATHER J. T. Eales

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Va.

12. MAIDEN NAME OF MOTHER Adelaide Lewis

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mo

PARENTS

14. INFORMANT (Address) E. E. Eales 909 Lindell

15. FILED 5/21, 1928 C. E. Strode REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 30 1928

17. I HEREBY CERTIFY That I attended deceased from 4:29, 1928, to 5:30, 1928 that I last saw him alive on 5:30, 1928, and that death occurred, on the date stated above, at 4:45 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia Labor
114/101/101 (duration) yrs. 1 mos. 1 ds.
CONTRIBUTORY (SECONDARY) Pneumonia (duration) yrs. 1 mos. 4 ds.

18. WHERE WAS DISEASE CONTRACTED At home 909 Lindell, Mo.
 IF NOT AT PLACE OF DEATH, _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) J. J. Brown, M. D.
5/31, 1928 (Address) Hannibal, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Church Hill Cem. DATE OF BURIAL June 1 1928

20. UNDERTAKER Wm. M. Smith ADDRESS Hannibal

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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