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

Do not use this space.

18756

JUL 26 1929

1. PLACE OF DEATH
County Maries
Township Miller
City ..... (No. ..... St. ..... Ward)

Registration District No. 1040
Primary Registration District No. 6276

File No. .....
Registered No. 5

2. FULL NAME Benjamin F Eads

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

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.

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 Amanda Eads

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1/31-1860

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
69	3	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(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) Missouri

PARENTS

10. NAME OF FATHER Louis Eads
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Missouri
12. MAIDEN NAME OF MOTHER Jane Simpson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Tenn

14. INFORMANT Manda Eads
(Address) Dixon Mo.

15. FILED 5-31, 19..... C W Winkelman
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 22 1929

17. I HEREBY CERTIFY, That I attended deceased from June 1st, 1924 to May 22, 1929 that I last saw him alive on May 23, 1929, and that death occurred, on the date stated above, at 6 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Heart Block.

127B
75A
(duration) 4 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Chalbcystitis & Cholangitis
(duration) 10 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 124B

8 DID AN OPERATION PRECEDE DEATH? DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) A. J. Crider, M.D
5/23, 1929 (Address) Dixon 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: Nadalick
DATE OF BURIAL: 5/24 1929

20. UNDERTAKER: Fred H Gilbert
ADDRESS: Dixon Mo

N. B.—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.

...RNET, WITH UNFADING INK—THIS IS A PERMANENT RECORD