

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

Do not use this space.

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PLACE OF DEATH

County Marion Registration District No. 542
Township Boone Primary Registration District No. 5731
City _____ (No. _____) St. _____ Ward _____

File No. 75-
Registered No. 7

2. FULL NAME Thomas W. 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. mo. 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 Salice E Eads

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 12/10/1883

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
50 5 25

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation 35

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

13. NAME James C. Eads

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri Marion

15. MAIDEN NAME Sarah Miles

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT (ADDRESS) Dallio E Eads
Vernon Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Vernon DATE 12/12/33

19. UNDERTAKER (ADDRESS) Fred St Gilbert
Dixon Mo

20. FILED Dec-21, 1933 Joseph W. Eads
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12/10 - 1933

22. I HEREBY CERTIFY, That I attended deceased from Nov. 19th - 21st - 28th 1933, to Dec. 4th 1933
I last saw him... alive on December 4th, 1933. Death is said to have occurred on the date stated above, at 1 P.M.

The principal cause of death and related causes of importance were as follows:
Suppurative Encephalitis Date of onset _____

Other contributory causes of importance:
Cardiac insufficiency with thromboses & pneumonia

Name of operation None Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19 _____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____

(Signed) W. H. Milligan M. D.
(Address) Frederick, Mo

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CERTIFICATE OF DEATH**

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1. PLACE OF DEATH

County Maxie's
Township Tacklean
City (No.)

Registration District No. 542
Primary Registration District No. 5731

File No. 75
Registered No. 7
St. Ward)

2. FULL NAME Thomas W. Eude

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

15. FILED 12/21, 1933 Thomas W. Eude REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/10 1933

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., that I last saw him alive on 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Suppurative Encephalitis in Cerebrum of Brain, caused by suppurative Mixed infection from teeth, middle Ear, influenza and Rheumatism (duration) yrs. mos. ds.

CONTRIBUTORY Toxemia, coma, Exhaustion from above. (SECONDARY)

Mitral Regurgitation and Stenosis due to Rheumatic Endocarditis (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Home

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? No. DATE OF No.

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS General Clinical sympt and Observation
(Signed) Dr. K. W. Milligan
Freeburg, Mo
1934 (Address)

*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 DATE OF BURIAL

20. UNDERTAKER ADDRESS

19

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

**MISSOURI STATE BOARD OF HEALTH
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ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jackson
Township Jackson
City Thomas W. Cade (No. _____ St. _____ Ward)

Registration District No. 512
Primary Registration District No. 5731

File No. 75
Registered No. 7

2. FULL NAME

Thomas W. Cade

(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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19

19. UNDERTAKER (ADDRESS)

20. FILED Dec - 21, 1933 Spring M. Cade Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12 / 10 , 1933

22. I HEREBY CERTIFY, That I attended deceased from _____, to _____, 19_____

I last saw h..... alive on _____, 19..... Death is said

to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Myocardial Infarction
Emphysema
Date of onset

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19_____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify _____

(Signed) _____, M. D.

(Address) _____

SUPPLEMENTARY