

REC'D MAY 10 1939

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

791  
1003

13326

Do not use this space.

3668

## 1. PLACE OF DEATH

- (a) County..... Registration District No.....  
(b) Township..... Primary Registration District No.....  
(c) City St. Louis..... (d) Street No. Barnes Hospital..... St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

## 2. PRINT FULL NAME

- (a) Residence, No. 2125 Oak..... St. NR Pine Lawn, Mo.  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX <b>Male</b>	4. COLOR OR RACE <b>White</b>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <b>Married.</b>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <b>Flossie Easley.</b>			
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <b>July 8, 1890</b>			
7. AGE	YEARS <b>48</b>	MONTHS <b>9</b>	DAYS <b>9</b>
	IF LESS than 1 day, ..... hrs. or ..... min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <b>Foreman</b>		
	9. Industry or business in which work was done, as saw mill, bank, etc. <b>Fayette R. Plumb</b>		
	10. Date deceased last worked at this occupation (month and year).....		
	11. Total time (years) spent in this occupation.....		
12. BIRTHPLACE (CITY OR TOWN) <b>Cairo,</b> (STATE OR COUNTRY) <b>Illinois.</b>			
FATHER	13. NAME <b>Thomas Easley.</b>		
	14. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY) <b>Illinois.</b>		
MOTHER	15. MAIDEN NAME <b>Emma Gunshire.</b>		
	16. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY) <b>Illinois.</b>		
17. INFORMANT <b>Mrs. Flossie Easley.</b> (ADDRESS) <b>2125 Oak Ave.</b>			
18. BURIAL, CREMATION, OR REMOVAL PLACE <b>Lake Charles Cem.</b> DATE <b>April 17, 1939</b>			

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **April 17, 1939.**

22. I HEREBY CERTIFY, That I attended deceased from

**4-11** 19**39** to **4-17** 19**39**I last saw him alive on **4-17** 19**39**. Death is saidto have occurred on the date stated above, at **9:30 a** m.

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

**Carcinoma of Rectum**

Date of onset

Other contributory causes of importance:

**Pulmonary Embolism**Name of operation **Colostomy** Date of **4/14/39**What test confirmed diagnosis?..... Was there an autopsy? **No**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) **A. O. Fisher**, M. D.(Address) **3720 Washington, St. Louis**

20. FILED

APR 20 1939

**J. E. Buddeck**  
Local Registrar

**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, 3454

David C. Gibson, or by \_\_\_\_\_

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed David C. Gibson

Licensed Embalmer No. 3454

P.O. Address \_\_\_\_\_

**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.**