

1939 AUG 11 1939

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

25066
Do not use this space.

1. PLACE OF DEATH
(a) County Buchanan 3 Registration District No. 85
(b) Township St. Joseph 1 Primary Registration District No. 1001 Registered No. 734
(c) City St. Joseph (d) Street No. State Hospital #2 St.
(e) Length of residence in city or town where death occurred all of life ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME BEN F. EASTBOURN 2009 Messanie
(a) Residence, No. State Hospital #2 St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

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 Artie Eastbourn
~~(OR) WIFE OF~~

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) ? 1873

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
66 7 2

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. barber
9. Industry or business in which work was done, as 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) St Joseph, Mo.
(STATE OR COUNTRY)

FATHER
13. NAME Francis Eastbourn
14. BIRTHPLACE (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Mo.

MOTHER
15. MAIDEN NAME Mary Brown
16. BIRTHPLACE (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Unknown

17. INFORMANT Mrs. Artie Eastbourn, St Joseph, Mo.
(ADDRESS) 2009 Messanie

18. BURIAL, CREMATION, OR REMOVAL
PLACE DeKalb, Mo. DATE July 17th 1939

19. FUNERAL DIRECTOR (NAME) FLEEMAN & SON INC.
(ADDRESS) 1946 Calhoun St. Joseph Mo.

20. FILED July 17, 1939 H. J. Nuttlebaum
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 15 1939

22. I HEREBY CERTIFY, That I attended deceased from Apr. 21 1939 to July 15 1939
I last saw him alive on July 16, 1939. Death is said to have occurred on the date stated above, at 8:50 a.m.
The principal cause of death and related causes of importance were as follows:
Arteriosclerosis Date of onset ?

Other contributory causes of importance:
Heat- fever - exhaustion 1 day

Name of operation none Date of _____
What test confirmed diagnosis? Placed 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? No
If so, specify _____
(Signed) J. T. G. Dell, M. D.
(Address) St. Joseph

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

99

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 _____

Licensed Embalmer No. 3986

P. O. Address Joseph, M.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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CERTIFICATE OF DEATH

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Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 85
 (b) Township _____ Primary Registration District No. 1001 Registered No. 734
 (c) City St. Joseph (d) Street No. _____
 (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 Bern F Eastbourn

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|--|--|---|
| 3. SEX <u>m</u> | 4. COLOR OR RACE <u>w</u> | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>w</u> |
| 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF | | |
| 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) | | |
| 7. AGE | YEARS <u>66</u> | MONTHS <u>-</u> |
| | DAYS <u>-</u> | If LESS than 1 day, _____ hrs. or _____ min. |
| OCCUPATION | 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. | |
| | 9. Industry or business in which work was done, as 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. FUNERAL DIRECTOR (ADDRESS) | | |
| 20. FILED _____ 19 _____ | | |

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-15, 1939

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

arterio sclerosis Date of onset 1911

Other contributory causes of importance:
Heart - Fever - Exhaustion
just as above stated
Heat fever - heat exhaustion - heat prostration see 191 in Manual

(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) T. J. Odell, M. D.
 (Address) St Joseph Mo

SUPPLEMENTARY

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

Local Registrar.

S. 25066 1939