WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

MAR 12 1940

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

6184
Do not use this space.

1. PLACE OF DEATH
(a) County Cape Girardeau Registration District No. 125
(b) Township Cape Girardeau Primary Registration District No. 3009 Registered No. 52
(c) City Cape Girardeau (d) Street No. 1 Southeast Mo 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 Troy H. Eakins Jr.
(a) Residence, No. Millersville Mo St. Millerville 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 Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 15-1937

7. AGE YEARS 2 MONTHS 5 DAYS 17 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) Millersville Mo.

FATHER
13. NAME Troy H. Eakins
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Burfordville Mo.

MOTHER
15. MAIDEN NAME Maine Slinkard
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Millersville Mo.

17. INFORMANT (ADDRESS) Troy H Eakins Millersville Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Fairview DATE Feb. 3, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Cracraft & Miller Jackson, Mo.

20. FILED 2-3 1940 J. M. Thompson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-3, 1940

22. I HEREBY CERTIFY, That I attended deceased from Jan 15, 1940, to Feb 3, 1940
I last saw him alive on Feb 3, 1940 Death is said to have occurred on the date stated above, at 12 30 p m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Colitis	3 wks
Other contributory causes of importance: Ulcerative pharyngitis	5 days

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) D R Shubrugha, M. D.
(Address) Jackson, Mo

(Licensed Embalmer's Statement on Reverse Side)

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.....

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.