No. 2
4-13-40
5-17-39
1 X23

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 15 1941 791

Registration District No.

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 40493

Registrar's No. 10264

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 3940 Olive St.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 3940 Olive St.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME George W. Eubank

3. (b) If veteran, name war Unknown

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Cora

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Dec. (Month) 20 (Day) 1875 (Year)

8. AGE: Years 64 Months 11 Days 21 If less than one day hr. min.

9. Birthplace (City, town, or county) Virginia (State or foreign country)

10. Usual occupation Hotel Owner

11. Industry or business

FATHER
12. Name Wilson Eubank
13. Birthplace (City, town, or county) Virginia (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace (City, town, or county) Unknown (State or foreign country)

16. (a) Informant Mrs. Williams
(b) Address 3940 Olive St.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/13/40 (Month) (Day) (Year)
(c) Place: burial or cremation Springfield, Ill.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Ave.

19. (a) DEC 13 1940 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 20 year 1940 hour 1 minute 15 A.M.

21. I hereby certify that I attended the deceased from March 25, 1940 to Nov 9, 1940 that I last saw him alive on Nov 9, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death [illegible]

Due to [illegible]

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature [illegible] (M. D. or coroner)
Address 1803 [illegible] Date signed 12-24-40

(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.....2971.....

P. O. Address.....

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

If this body is not embalmed, fact should be so stated above.