

S. No. 2
M-9-4-41
v. 5-17-39
I X29484

25808

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

FILED SEP 4 1942 318

Registration District No.

Primary Registration District No. 1003

Registrar's No. 7160

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17
9
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County.....

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

(c) Name of hospital or institution:
Residence:- 5530/Cates Ave.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... (Specify whether)

In this community.....
years, months or days

2. USUAL RESIDENCE OF DECEASED: 000

(a) State Missouri. (b) County 17

(c) City or town St. Louis. 95
(If outside city or town limits, write "RURAL")

(d) Street No. 5530 Cates Avenue.
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country no.

3. (a) PRINT FULL NAME Emma Hollister Eaton

3. (b) If veteran, name war none

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 25th
year 1942 hour 1:00 minute P. M.

4. Sex Female / 5. Color or race White / 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Alfred F. Eaton 6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased: June 27, 1869
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 8.17-42
for Dr. Fred Blad. 1942 to 8-26- 1942
that I last saw her alive on 8-26- 1942
and that death occurred on the date and hour stated above.

Immediate cause of death cerebral hemorrhage Duration

8. AGE: Years 73 Months 1 Days 28 If less than one day
hr. min.

Due to hypertension
chronic nephritis

Due to diabetes
arterio sclerosis

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

9. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

PHYSICIAN

Underline the cause to which death should be charged statistically.

11. Industry or business.....

12. Name Arthur T. Hollister

13. Birthplace New York
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant A. F. Eaton

(b) Address 5530 Cates Avenue

17. (a) burial (b) Date thereof Aug. 27/42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine Cemetery

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?

18. (a) Signature of funeral director C. R. Lupton & sons

(b) Address 7333 Delmar Boulevard

19. (a) AUG 26 1942 (b) J. F. Bruders
(Date received local registrar) (Registrar's signature)

While at work (Specify type of place) (c) Means of injury

23. Signature W. B. ... (M. D. or other) W. B.

Address 4560 Olive St Date signed 8/26/42

844 (Licensed Embalmer's Statement on Reverse Side)

Dr. R. W. Bennett
Eastern Building
Hrs. 2-6

FO-3800
Hrs. 2-6

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 Bridford A. Miles
Licensed Embalmer No. 2901
P. O. Address University City, N

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, fact should be so stated above.