

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 426A

FILED JAN 31 1944
Registration District No. 3147

Primary Registration District No. 3063

Registrar's No. 162

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 month 9 days
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Kirkwood
(If outside city or town limits, write "RURAL")
(d) Street No. 434 West Essex
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Dorothy Eaves

3. (b) If veteran, name war -- 3. (c) Social Security No. ---

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

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

7. Birth date of deceased 4-14-1927
(Month) (Day) (Year)

8. AGE: Years 16 Months 9 Days 3 If less than one day hr. _____ min.

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

10. Usual occupation Student

11. Industry or business --

MOTHER FATHER {
12. Name Edward Eaves
13. Birthplace Doe Run Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Catherine Barr (Dec.)
15. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Edward Eaves

(b) Address 434 W. Essex Ave. Kirkwood, Mo.

17. (a) Burial (b) Date thereof 1-19-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Marcus Cem.

18. (a) Signature of funeral director Mittelberg, Fun. Home, Inc.

(b) Address Webster, St. Louis, Mo.

19. (a) JAN 22 1944 (b) E. G. McKeever, M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1-17-44 day _____
year _____ hour 12:00 minute A.M.

21. I hereby certify that I attended the deceased from 12-9-43 19____ to 1-17-44 19____
that I last saw her alive on 1-17-44 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Meningitis Duration _____

Due to Tuberculosis

Due to Tuberculous Peritonitis

Other conditions Cross T.B.C. y. close.
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy 15
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?
While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature [Signature] (M. D. or other) M.D.
Address St. Louis County, Mo. Date signed 1-17-44

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

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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

Jalen M. Meyer

Licensed Embalmer No.

3288

P. O. Address

Kirkwood, Mo.

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.