

U.S. No. 2
 FORM 5-43
 REV. 5-17-39
 No. X36671

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 28737
 Registrar's No. 1800

FILED SEP 2 1944

Registration District No. 317 Primary Registration District No. 3066

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

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County St. Louis
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 820 Cherry St
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Thomas Clinton Eudicott
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Div
 6. (b) Name of husband or wife Lilah 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased March 13-1897
 (Month) (Day) (Year)

8. AGE: Years 68 Months 5 Days 12 If less than one day hr. _____ min. _____

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

10. Usual occupation Retired

11. Industry or business _____

12. Name Thomas Eudicott

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

14. Maiden name Sally Williams

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

16. (a) Informant John H. Huber

(b) Address 820 Cherry St. St. Louis, Mo.

17. (a) Burial (b) Date thereof 8-27-44
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MARISSA, Ill.

18. (a) Signature of funeral director Louis H. Poppendick

(b) Address St. Louis, Mo.

19. (a) AUG 29 1944 (b) C. D. McGowan, M.D.
 (Date of death) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Aug day 25
 year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from July 23 1944 to Aug 25 1944
 that I last saw him alive on August 24 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis
 Due to Arterio Sclerosis
 Due to Senility
 Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: Of operations none
 Of autopsy 93%

Duration
1944
plus
1944
1944
 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 _____ (Specify type of place)
 (c) Means of injury _____
 23. Signature Robert P. Smith (M. D. or other)
 Address 5205 1/2 Chippewa St Date signed 8/29/44

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

MOTHER FATHER

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.....
John M. Squire

Licensed Embalmer No. *43-43*

P. O. Address *2415 Zephyr Pl.
Morgantown, 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.

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