

No. 2-43
-17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF VITAL RECORDS
FILED SEP 15 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29034**

Registration District No. **370**

Primary Registration District No. **6288**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Wayne St. Francis**

(b) City or town **Piedmont (Rural)**

(c) Name of hospital or institution: _____

(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution **1**

(Specify whether _____)

In this community _____

years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo**

(b) County **Wayne**

(c) City or town **Piedmont (Rural)**

(If outside city or town limits, write "RURAL")

(d) Street No. _____

(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME **Joe Sylvester Eads**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **24**

year **1944** hour **11:10** minute _____ P. M.

21. I hereby certify that I attended the deceased from **past 3 years**

_____ 19____ to _____ 19____

that I last saw him _____ alive on _____ 19____

and that death occurred on the date and hour stated above.

4. Sex **Male**

5. Color or race **White**

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

(b) Name of husband or wife **Elken Eads**

6. (c) Age of husband or wife if alive **70** years

7. Birth date of deceased **Jan 25 1860**

(Month) (Day) (Year)

8. AGE: Years **84** Months **5** Days **29**

If less than one day _____ hr. _____ min.

Immediate cause of death **Dr. resolutely despondent, habit arthrosis, cardiac vascular disease**

Due to _____

Due to _____

Other conditions _____

(Includes pregnancy within 3 months of death)

9. Birthplace **North Carolina**

(City, town, county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

MOTHER FATHER { 12. Name **Alfred Eads**

13. Birthplace **Don't Know**

(City, town, county) (State or foreign country)

14. Maiden name **Melba M. Daniels**

15. Birthplace **Don't know**

(City, town, county) (State or foreign country)

16. (a) Informant **Mr. Noah E. Eads**

(b) Address **Piedmont (Rural) Mo.**

17. (a) **Rural** (b) Date thereof **7/25/44**

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Green Hill Cemetery (Wayne Co)**

18. (a) Signature of funeral director **William Baker**

(b) Address **Piedmont**

19. (a) _____ (b) _____

(Date received local registrar) (Registrar's signature)

Major findings: **978**

Of operations _____

Of autopsy _____

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? _____

23. Signature **W. H. Clinch, M.D.**

(Specify type of place) (e) Means of injury _____

Address **Piedmont, Mo** Date signed **8/24/44**

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

1222

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.....

Coder Funeral Home Registered Apprentice No.
working under my personal supervision.

Signed *William Coder*

Licensed Embalmer No. *3723*

P. O. Address: *Piedmont, N.C.*

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.

Registration District No. 370

Primary Registration District No. 62 of 8

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Wayne
(b) Rural St. Francis Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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

3. (a) PRINT FULL NAME Joel Sylvester Eads

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

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

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

7. Birth date of deceased Jan 25 (Month) (Day) (Year)

8. AGE: Years 84 Months 5 Days _____ If less than one day _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) N.C.

10. Usual occupation _____

11. Industry or business _____

12. Name Alfred Eads

13. Birthplace _____ (City, town, or county) (State or foreign country) D.K.

14. Maiden name _____

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

16. (a) Informant Mrs. Math E. Eads

(b) Address Piedmont Mo.

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof 7-25-44 (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 7-26-1944 (Date received local registrar) (b) Fred Bennett (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 25 Year 1944 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTAL

HEMorrhage

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

29034