

S. No. 2
OM-2-43
v. 5-17-39
I X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30210**
Registrar's No. **246**

FILED SEP 22 1945
Registration District No. **43**

Primary Registration District No. **4058**

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

1. PLACE OF DEATH:

(a) County Buttler

(b) City or town Harwill, Mo.
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buttler

(c) City or town Harwill, Mo.
(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 _____

3. (a) PRINT FULL NAME Vesta Bow Eaker

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 26 year 1945 hour 5 minute 30 P.M.

5. Color or race White

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

6. (b) Name of husband or wife Morris Eaker

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased: Feb 13 1880
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Aug 15 1945 to Aug 25 1945 that I last saw u alive on Aug 25 1945 and that death occurred on the date and hour stated above.

8. AGE: Years 65 Months 6 Days 13 If less than one day _____ hr. _____ min.

Immediate cause of death Cerebral Hemorrhage Duration _____

Due to Cerebral Arteriosclerosis

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

Due to _____

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

10. Usual occupation Housewife

Major findings: Of operations 830

Of autopsy _____

PHYSICIAN _____ Underline the cause to which death should be charged statistically.

MOTHER FATHER { 11. Industry or business _____

12. Name Dr. Quincy

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

14. Maiden name Evangelina Hayes

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

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? _____

16. (a) Informant Quincy Eaker

(b) Address Portland Ore.

17. (a) Burial (b) Date thereof 8-27-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Gravesy Hill

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. Schumert (M. D. or other) _____
Address Granny Ark Date signed 8-26-45

18. (a) Signature of funeral director J. J. Schumert

(b) Address Granny Ark

19. (a) 8-27-45 (b) W. H. Mendenhall
(Date received local registrar) (Registrar's signature)

RECEIVED

District Health Office No. 2,

District File Number

945-3038

Date Filed

9-17-45

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 Valus Johnson

Licensed Embalmer No. 686 # 4371

P. O. Address Canning Park

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.