

1. PLACE OF DEATH:

(a) County St. Francois  
(b) City or town Farmington RURAL St. Francois  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: State Hospital No. 4 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 mos., 20 das.  
In this community 3 months, 20 days  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME JOHN HENRY EATON

3. (b) If veteran, name was None 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Cassie Bannister 6. (c) Age of husband or wife if alive Deceased years

7. Birth date of deceased December 3 1862  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>83</u>	<u>6</u>	<u>28</u>	hr. min.

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

10. Usual occupation Laborer in mines

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Jesse Eaton

13. Birthplace St. Francois Co. Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Mary J. Fields

15. Birthplace St. Francois County Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Records State Hospital No. 4

(b) Address Farmington, Missouri

17. (a) Burial (b) Date thereof July 3, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Parkview Cem., Farmington, MO.

18. (a) Signature of funeral director C. J. Loye

(b) Address Disloge Mo

19. (a) 7-17-46 (b) Ether Rudloff  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois  
(c) City or town Bonne Terre  
(If outside city or town limits, write "RURAL")  
(d) Street No. 114 Shepard Street  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 1  
year 1946 hour 11 minute 40 A.M.

21. I hereby certify that I attended the deceased from April 19, 1946 to July 1, 1946  
that I last saw him alive on July 1, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death: Myocarditis  
Duration \_\_\_\_\_

Due to Antemortem

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy None

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 George H. Reuss (M. D. or other) MD

Address Farmington Mo Date signed 7/13/46

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

23593

RECEIVED

District Health Officer No. 4

District File Number 846-2463

Date Filed: 8-9-46

**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 S. T. Sawyer

Licensed Embalmer No. 3660

P. O. Address Keokuk, 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.**