

S. No. 2
M-8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

25973

FILED AUG 1 1946

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 338

Primary Registration District No. 6148

Registrar's No. _____

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

1. PLACE OF DEATH:
 (a) County: Stoddard
 (b) City or town: Bloomfield Rural
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: County Home
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution: 8 years
 In this community: 63 years
 years, months or days)

3. (a) PRINT FULL NAME: Will Eaton
 3. (b) If veteran, name war: none
 3. (c) Social Security No. _____

4. Sex: male 5. Color or race: white
 6. (a) Single, widowed, married, divorced, divorced
 6. (b) Name of husband or wife: Sissy 6. (c) Age of husband or wife if alive: _____ years
 7. Birth date of deceased: June 9 1879
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
67 1 11 _____ hr. _____ min.

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

10. Usual occupation: Farmer

11. Industry or business: _____

MOTHER FATHER
 12. Name: Berry Eaton
 13. Birthplace: Tennessee
 (City, town, or county) (State or foreign country)
 14. Maiden name: Sarah S. Barnett
 15. Birthplace: Indiana
 (City, town, or county) (State or foreign country)

16. (a) Informant: Albert Eaton
 (b) Address: Essex, Missouri

17. (a) Burial (b) Date thereof: July 21 1946
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Essex Cemetery

18. (a) Signature of funeral director: Wathia Funeral Home

(b) Address: Bloomfield, Missouri

19. (a) 7-26-46 (b) Rose Webber
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State: Missouri (b) County: Stoddard
 (c) City or town: Bloomfield Star Route
 (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: _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 20
 year 1946 hour 7 minute _____ M.
 21. I hereby certify that I attended the deceased from July 8
 19 46 to July 20 19 46
 and that death occurred on the July 19 19 46
 and hour stated above.

Immediate cause of death: Coronary thrombosis
 Due to: Chronic Myocarditis
 Duration: 8 days
2 yrs.

Other conditions: _____
 (Include pregnancy within 3 months of death)
 Major findings: None performed
 Of operations: _____
 Of autopsy: None performed

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?
 (Specify type of place)

While at work? _____ (e) Means of injury: 0 MO

23. Signature: Dr. Jones (M. D. or other) MO
 Address: Bloomfield Mo Date signed: July 21 1946

333

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Office No. 2,

District File Number 246-906

Date Filed 7-29-46

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..... Lynna Steele

Licensed Embalmer No. 2476

P. O. Address Hexter 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.