

FILED APR 23 1947
318

Registration District No. _____ Primary Registration District No. **100** Registrar's No. _____

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Frisco Hospital
(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 **Walter H. Eastin**
3. (b) If veteran, name war **None** 3. (c) Social Security No. **702-03-6250**

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Evalin Eastin** 6. (c) Age of husband or wife if alive **58** years
7. Birth date of deceased **August 21 1879**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
67 7 16 hr. min.

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

10. Usual occupation **Conductor**

11. Industry or business **Frisco Railroad**

MOTHER FATHER
{ 12. Name **Thomas Benton Eastin**
{ 13. Birthplace **Unknown Unknown**
(City, town, or county) (State or foreign country)
{ 14. Maiden name **Elizabeth Elsie Kindred**
{ 15. Birthplace **Unknown Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Evalin Eastin**
(b) Address **818 West Oklahoma, Enid Okla**
17. (a) **Removal** (b) Date thereof **4/7/47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Enid, Oklahoma**

18. (a) Signature of funeral director **Albert H. Hoppe**
(b) Address **4700 Washington Blvd.**

19. (a) **APR 7 1947** (b) **J. F. Bredick**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Oklahoma** (b) County **Garfield**
(c) City or town **Enid**
(If outside city or town limits, write "RURAL")
(d) Street No. **818 West Oklahoma**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **April** day **7**
year **47** hour **9** minute **20 A.M.**
21. I hereby certify that I attended the deceased from **March 5**, 19**47** to **April 7**, 19**47**
that I last saw him alive on **April 7**, 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of Colon E metastatic**
Duration **3 mo**

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) **Hb**

PHYSICIAN
Major findings:
-Of operations _____
Of autopsy _____
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 **James C. [Signature]** (M. D. or other) **MD**
Address **4860 Parkers, [Address]** Date signed **4/7/47**

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 *W. W. Wilkins*

Licensed Embalmer No. *3575*

P. O. Address.....

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. *318*

Primary Registration District No. *1003*

Registrar's No. *3690*

1. PLACE OF DEATH:

(a) County _____
(b) City or town *St Louis*
(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

Walter H. Easter

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex *m* race *A*

5. Color *A*

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased *aug 2*
(Month) (Day) (Year)

8. AGE: Years *67* Months *7* Days _____ If less than one day
hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____
13. Birthplace _____
(City, town, or county) (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) *J. F. Bredeek*
(Date received local registrar) (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 _____
year *1947* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ alive on _____, 19____;

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

Immediate cause of death _____

Duration _____

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER, FATHER

15024

✓
a-a-s-o-ey