

S. No. 2
-12-45
5-17-39
P I X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 29 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18772**
Registrar's No. **4769**

Registration District No. **318** Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County **St. Louis**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3202 Chippawa
(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 **Lillian M. Eagan**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **F** / race **W** 5. Color or race **W**
6. (a) Single, widowed, married, divorced **Widow**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **June 23 1873**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
73 10 17 hr. min.

9. Birthplace **Ohio**
(City, town, or county) (State or foreign country)
10. Usual occupation **Store Keeper**

11. Industry or business _____
12. Name **John Matthews**
13. Birthplace **England** 4
(City, town, or county) (State or foreign country)
14. Maiden name **Not Known**
15. Birthplace **England** 4
(City, town, or county) (State or foreign country)

MOTHER FATHER

16. (a) Informant **Adele Eagan**
(b) Address **3649a Willmington**
17. (a) **Burial** (b) Date thereof **5-13-1947**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Calvary Cemetery**
18. (a) Signature of funeral director **Schumacher Und Co.**
(b) Address **3013 Meramec st.**
19. (a) **MAY 12 1947** (b) **J. F. Bredbeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **022**
(c) City or town **St. Louis** **17**
(If outside city or town limits, write "RURAL")
(d) Street No. **3202 Chippawa** **9**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No) **0**
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **10**
year **1947** hour **7** minute **A** M.
21. I hereby certify that I attended the deceased from **Aug.**
_____, 1942, to **May 10**, 1947
that I last saw her alive on **MAY 9**, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**
Due to **Arteriosclerosis and Hypertension** **5 yrs**
Due to _____
Other conditions **Chronic Endo**
(Include pregnancy within 3 months of death)
Major findings: **carditis**
Of operations _____
Of autopsy _____

Duration
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 **D. S. Johnson** (M. D. or other) **m.d.**
Address **2801 Chippawa** Date signed **5-12-**
D. I. JOHNSON

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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..... *Alfred Grayfield*
Licensed Embalmer No. *3077*
P. O. Address..... *St. Louis, 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.

F. A. Williamson