FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JUL 3 1948

Registration District No. 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 20821

Primary Registration District No. 1003

Registrar's No. 5824

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: Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 Hrs 45 Min. (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County

(c) City or town: St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No.: 1429 Papin Street
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Infant Eason

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: Male

5. Color or race: Negro

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

6. (b) Name of husband or wife

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

7. Birth date of deceased: 6 (Month) 6 (Day) 48 (Year)

8. AGE: Years | Months | Days | If less than one day: 7 hr. 45 min.

9. Birthplace: St. Louis (City, town, or county) Missouri (State or foreign country)

10. Usual occupation

11. Industry or business

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

MOTHER
14. Maiden name: Fleete Eason
15. Birthplace: St. Louis (City, town, or county) Missouri (State or foreign country)

16. (a) Informant: Esther M. Sherard KRL
(b) Address: 2601 N. Whittier Street

17. (a) Anatomical Board (Burial, cremation, or removal) (b) Date thereof: JUN 30 1948 (Month) (Day) (Year)
(c) Place: burial or cremation: Anatomical Board

18. (a) Signature of funeral director: Rowland Mortuary Service
(b) Address: 4104 Manchester Ave.

19. (a) JUN 30 1948 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 7 year 1948 hour 4 minute 30 a.m.

21. I hereby certify that I attended the deceased from 6-6-48 19 to 6-7 19 48 that I last saw him alive on 6-7 19 48 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Prematurity	
Due to: Unknown	
Due to: Unknown	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause of 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

23. Signature: (M. D. or other)

Address: 2601 N. Whittier Date signed: 6/10/48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.