

FILED AUG 9 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22523

BIRTH NO. _____ REG. DIST. NO. 38 PRIMARY REG. DIST. NO. 3006 Registrar's No. 198

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

1. PLACE OF DEATH a. COUNTY Boothe			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Boothe		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Columbia, Missouri		c. LENGTH OF STAY (in this place) 2 1/2 Hours	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN West Plains		d. STREET ADDRESS (If rural, give location) 1
d. FULL NAME OF HOSPITAL OR INSTITUTION University Hospital			4. DATE OF DEATH (Month) (Day) (Year) July 17 1949		
3. NAME OF DECEASED (Type or Print) William	a. (First)	b. (Middle) Dennis	c. (Last) Eakin	5. SEX Male	6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 12-29-1944	9. AGE (In years last birthday) 4	if UNDER 1 YEAR Months	if UNDER 24 HRS. Hours	if UNDER 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Mo	
12. CITIZEN OF WHAT COUNTRY? America					

13a. FATHER'S NAME Woodrow W. Eakin		13b. MOTHER'S MAIDEN NAME Jenievee-Jane Eakin		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME _____ ADDRESS _____	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Anterior Polio myelitis (Bulbar) 3 1/2 days			INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (b) _____			
DUE TO (c) _____				
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	None		0800	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on **July 13, 1949**, and that death occurred at **11:30 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Kingil R. May Jr. M.D.		23b. ADDRESS University Hospital		23c. DATE SIGNED 13 July 49	
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 7-15-49	24c. NAME OF CEMETERY OR CREMATORY Oak Lawn	24d. LOCATION (City, town, or county) (State) West Plains, Mo		
DATE REC'D BY LOCAL REG. August 2 1949	REGISTRAR'S SIGNATURE Mrs R E Palmer		31	25. FUNERAL DIRECTOR'S SIGNATURE Charles J. ... ADDRESS ...	

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RECEIVED
AUG 8 1949
District Health Officer No. 9,
District File Number:

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

A. J. Roberts

Licensed Embalmer No. *3437*

P. O. Address *West Haven*

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.