

FILED SEP 2 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26880

State File No. ....

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BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 3554

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Illinois</u> b. COUNTY <u>MASSAC</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Mounds Illinois</u>	
c. LENGTH OF STAY (in this place) <u>3 weeks</u>		d. STREET ADDRESS (If rural, give location) <u>2600 Wabash Ave</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Wheatley Hospital</u>			
3. NAME OF DECEASED a. (First) <u>Samuel</u> b. (Middle) _____ c. (Last) <u>Eason</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 13-1949</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>August 29 74</u>
9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Marianna Ark</u>	12. CITIZEN OF WHAT COUNTRY? <u>U-S-A</u>
13a. FATHER'S NAME <u>Silas Eason</u>		13b. MOTHER'S MAIDEN NAME <u>Don't Know</u>	
14. NAME OF HUSBAND OR WIFE <u>Deceased Augusta Eason</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Troy Bell</u>		ADDRESS <u>2600 Wabash</u>	
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, asthenia, etc. It means the disease, injury, or complication which caused death.		19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <u>(a) Bronchopneumonia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>(1) Broncho-genic Carcinoma Right Lung Primary</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>162</u>	
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 <u>July 5, 1949</u> to <u>Aug. 13, 1949</u> , that I last saw the deceased alive on <u>Aug. 13, 1949</u> , and that death occurred at <u>9:30 pm.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Royce B. Fleming</u> (Degree or title) <u>M.D.</u>		23b. ADDRESS <u>1433 E-19th St</u>	
23c. DATE SIGNED <u>8/16/49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>August 16-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Blue Ridge Lawn Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Kansas City Mo.</u>
DATE REC'D BY LOCAL REG. <u>8-17-49</u>		REGISTRAR'S SIGNATURE <u>Seraldine Holmes</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>West, Appleton &amp; Jones</u>		ADDRESS _____	

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

**STATEMENT BY LICENSED EMBALMER**

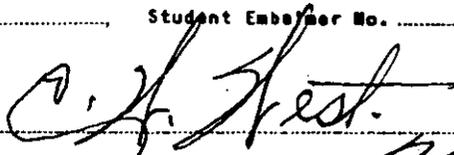
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed



Licensed Embalmer No. \_\_\_\_\_

2710

P. O. Address \_\_\_\_\_

15. C. 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.