

FILED NOV 4 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34856

State File No. ....

94  
000

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 6070 Registrar's No. 379

|  |                               |  |  |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>St. Francois</u>   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>St. Francois</u> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) <u>Libertyville</u>   |                               | c. CITY (If outside corporate limits, write RURAL and give township) <u>Libertyville</u> 94  |  |
| c. LENGTH OF STAY (In this place) <u>5yrs.</u>   |                               | d. STREET ADDRESS (If rural, give location)  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Libertyville, Mo.</u>   |                               |  |  |
| 3. NAME OF DECEASED<br>a. (First) <u>Leonard Dale</u> b. (Middle) <u>Eaves</u> c. (Last)   |                               |  | 4. DATE OF DEATH (Month) (Day) (Year) <u>October 14 1949</u> |
| 5. SEX <u>male</u>   | 6. COLOR OR RACE <u>white</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>child</u>  | 8. DATE OF BIRTH <u>January 4, 1935</u>                      |
| 9. AGE (In years last birthday) <u>14</u> Months <u>9</u> Days <u>10</u>   |                               | 10. KIND OF BUSINESS OR INDUSTRY <u>none</u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>child</u>   |                               | 11. BIRTHPLACE (State or foreign country) <u>Desloge, Missouri</u> D   |  |
| 13a. FATHER'S NAME <u>D. T. Eaves</u>  |                               | 13b. MOTHER'S MAIDEN NAME <u>Nora Benham</u>   |  |
| 14. NAME OF HUSBAND OR WIFE  |                               | 17. INFORMANT'S SIGNATURE OR NAME <u>D. T. Eaves</u> ADDRESS <u>Libertyville, Mo.</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>   |                               | 16. SOCIAL SECURITY NO. <u>none</u>  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.  |                               |  |  |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchopneumonia</u>   |                               | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>   |  |
| ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Influenza</u>  |                               | 1 week   |  |
| DUE TO (c) <u>Cere</u>   |                               |  |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <u>Cerebral palsy</u>  |                               | 183X   |  |
| 19a. DATE OF OPERATION <u>none</u>   |                               | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 19b. MAJOR FINDINGS OF OPERATION   |                               | 21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)   |                               | 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>October 14, 1949</u> , to <u>October 14, 1949</u> , that I last saw the deceased alive on <u>October 14, 1949</u> , and that death occurred at <u>8:00 P. m.</u> , from the causes and on the date stated above. |                               |  |  |
| 23a. SIGNATURE <u>M. Grooman</u> (Degree or title) <u>MD</u>   |                               | 23b. ADDRESS <u>Federicktown Mo</u>  |  |
| 23c. DATE SIGNED <u>10/15/49</u>   |                               |  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                               | 24b. DATE <u>OCT. 17, 49</u>   |  |
| 24c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN CEMETERY</u>  |                               | 24d. LOCATION (City, town, or county) (State) <u>LEADINGTON, Mo</u>  |  |
| DATE RECEIVED BY LOCAL REG. <u>Oct. 24, 1949</u>   |                               | REGISTRAR'S SIGNATURE <u>Esther Rudloff</u> 289  |  |
| 25. FUNERAL DIRECTOR'S SIGNATURE <u>B.T. Boyer</u>   |                               | ADDRESS <u>Desloge, Mo</u>   |  |

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

RECEIVED 11-1-49

District Health Officer No. Y

District File Number 1149-1444

Date Filed \_\_\_\_\_

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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 \_\_\_\_\_

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

working under my personal supervision.

Student .....  
Student Embalmer

Signed C. Z. Boyer

Licensed Embalmer No. ~~1671~~ 1671

P. O. Address Desloge, 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.