

FILED AUG 7 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22797

State File No.

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 863

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u> <u>1117</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph's Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>2218 Jules</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Edith</u> b. (Middle) <u>M.</u> c. (Last) <u>Eads</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 26, 1950</u>		
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5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>March 28, 1891</u>	9. AGE (In years last birthday) <u>59</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>28</u>	IF UNDER 4 HRS. Hours <u>4</u> Min. <u>15</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (State or foreign country) <u>Orrick, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>William Schooley</u>	13b. MOTHER'S MAIDEN NAME <u>Lucy Tucker</u>	14. NAME OF HUSBAND OR WIFE <u>Pierce E. Eads</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. (If you, give war or date of service) <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Pierce E. Eads</u>	ADDRESS <u>2218 Jules, St. Joseph, Mo.</u>
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>2976x</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) <u>Perforating gunshot wound through frontal lobe of brain + Foreign body entered right temple + made exit at left temple.</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Entered right temple</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>Coroner: Investigated death</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Suicide</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>St. Joseph Buchanan Mo</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	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 7-26, 1950, to 7-26, 1950, that I last saw the deceased alive on 7-26, 1950, and that death occurred at 9:28A m., from the causes and on the date stated above.

23. SIGNATURE (Degree or title) <u>W. B. Ross M.D.</u>	23b. ADDRESS <u>510 Carly Bldg.</u>	23c. DATE SIGNED <u>7/27/50</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>7-28-50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>	24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>July 31, 1950</u>	REGISTRAR'S SIGNATURE <u>E. G. Jenkins</u>	382 FUNERAL DIRECTOR'S SIGNATURE <u>O. Neata-Baumgardner</u>	ADDRESS <u>St. Joseph, Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Root

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 *William Spalding*

Licensed Embalmer No. *4535*

P. O. Address *319 S. 10th St. Joseph 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.