

No. 300
10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42893

JAN 16 1952

318

1003

State File No. _____

Registrar's No. 11536

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No. _____			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>2061</u>					
b. CITY (If outside corporate limits, write RURAL and give township) <u>ST. LOUIS, MISSOURI</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		d. STREET ADDRESS (If rural, give location) <u>1931 Burns</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSPITAL #1</u>									
3. NAME OF DECEASED a. (First) <u>HAZEL</u> (Type or Print) <u>LUCILLE</u>			b. (Middle) _____		c. (Last) <u>EADS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>DEC. 25, 1951</u>		
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>Aug 21, 1915</u>		9. AGE (In years last birthday) Months Days Hours Min. <u>36</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Veuna, Mo</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>John Bunyan</u>			13b. MOTHER'S MAIDEN NAME <u>Hellie Schockley</u>			14. NAME OF HUSBAND OR WIFE <u>Wm. Thomas Eads</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. _____		17. INFORMANT'S SIGNATURE OR NAME <u>For J. O. Ragan</u>				ADDRESS <u>AFTON MO</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u>5-1-51</u>				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cirrhosis of Liver (hepatic)</u>				INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused 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.									
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) m. _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR <u>5811</u>					
22. I hereby certify that I attended the deceased from <u>12-16-51</u> , 19 <u>51</u> , to <u>12-25-51</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>12-25-51</u> , 19 <u>51</u> , and that death occurred at <u>9:00P</u> m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>F. Coleman M.D.</u>				23b. ADDRESS <u>1515 Lafayette Avenue</u>				23c. DATE SIGNED <u>12-26-51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>12-26-51</u>		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) <u>Veuna Mo.</u>			
DATE REC'D BY LOCAL REG. <u>DEC 27 1951</u>		REGISTRAR'S SIGNATURE <u>Earl Smith M.D.</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>Rowland Mortuary Service</u>				
					ADDRESS <u>Manchester Ave.</u>				

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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

[Handwritten signature]
[Handwritten signature]

Licensed Embalmer No.

P. O. Address _____

Signed.....
Student Embalmer

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.

THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF VITAL STATISTICS

42893
11536

State of..... }
County of..... } ss.

State File No.....
Local Registrar's No.....

AFFIDAVIT FOR CORRECTION OF A RECORD

On this..... day of....., 19....., before me appears.....

for Hazel Eade, who, upon..... oath, states that the original record of ^{birth} death
died 12. 25, 1951 in the State of
born.....
Missouri, and which was filed at..... on....., 19....., should be corrected as follows:

Item No. 3 should read Hazel Eade

Instead of.....

Item No. 17 should read Lucille "

Instead of.....

Item No..... should read Joe O. Ragon

Instead of.....

Item No..... should read Joe "

Instead of.....

Item No..... should read.....

Instead of.....

The above is true to the best of my knowledge, information and belief

(SEAL)

X Affiant Joe O. Ragon Brother
Relationship.

80 Montague Ct. Altoon 23. MO.
Present Address.

Subscribed and sworn to before me this 7 day of Jan., 1952

My Commission expires 3-4-53 Chas C. Pabber Notary Public.

Affidavits containing erasures will not be accepted; draw one line through error and write above it.