

FILED JAN 28 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3592**

| | | | | | | | | | |
|---|-------------------------------|--|---|--|---|---|---|---|--|
| BIRTH NO. _____ | | REG. DIST. NO. 333 | | PRIMARY REG. DIST. NO. 3074 | | Registrar's No. 7 | | | |
| 1. PLACE OF DEATH a. COUNTY Scott | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri | | | | b. COUNTY New Madrid | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sikeston | | c. LENGTH OF STAY (in this place) 1 Day | | c. CITY OR TOWN New Madrid | | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Delta Community Hospital | | | | e. STREET ADDRESS (If rural, give location) Route 1, Box 22 | | | | 0720 | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Jane | | | b. (Middle) Elizabeth | | c. (Last) Eaves | | 4. DATE OF DEATH (Month) (Day) (Year) 1 15 1955 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married | | 8. DATE OF BIRTH 6-10-1952 | | 9. AGE (In years last birthday) 2 | IF UNDER 1 YEAR Months 7 | IF UNDER 4 HRS. Days 3 Hours 5 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | 11. BIRTHPLACE (City and State or Foreign Country) Caruthersville, Missouri | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13a. FATHER'S NAME John Eaves | | | 13b. MOTHER'S MAIDEN NAME Maggie Morgan | | 14. NAME OF HUSBAND OR WIFE 0 | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) No | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Maggie Eaves, New Madrid, Mo. | | | | | |
| 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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Extensive 2nd degree burns over most of entire body ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) none II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 day | | |
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION _____ | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) <input checked="" type="checkbox"/> | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) New Madrid 072 Mo. | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Jan 14 1955 4:00 p.m. | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? Laying at home - clothes burned off | | | | | |
| 22. I hereby certify that I attended the deceased from 14 Jan 1955 , to 15 Jan 1955 , that I last saw the deceased alive on 15 Jan 1955 , and that death occurred at 12:30 P.m. , from the causes and on the date stated above. | | | | | | | 23c. DATE SIGNED 18 Jan 55 | | |
| 23a. SIGNATURE (Degree or title) H.B. Shugrater M.D. | | | 23b. ADDRESS Sikeston, Missouri | | | | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE 16 Jan 55 | 24c. NAME OF CEMETERY OR CREMATORY Mounds Cemetery | | 24d. LOCATION (City, town, or county) (State) Near New Madrid Mo | | | | |
| DATE REC'D BY LOCAL REG. 1-19-55 | | REGISTRAR'S SIGNATURE Mrs. C. Hunter | | 25. FEDERAL DIRECTOR'S SIGNATURE ADDRESS Richardson, Ark. Mo. New Madrid Mo | | 429 | | | |

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

DATE RECEIVED JAN 24 1955

SCOTT CO. HEALTH DEPT.

CO. FILE No. 155-16

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.....
Signature of Student Embalmer

Signed Tommy S. Roberts
Licensed Embalmer No. 488

P. O. Address New Market

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.