

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED MAR 19 1956

BIRTH NO. _____		REG. DIST. NO. <u>75</u>		PRIMARY REG. DIST. NO. <u>3015</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>CLINTON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CLINTON</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>CAMERON</u>		c. LENGTH OF STAY (In this place) <u>1</u>		c. CITY OR TOWN <u>LATHROP</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>CAMERON COMMUNITY HOSP.</u>				e. STREET ADDRESS (If rural, give location) _____			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Billy</u> b. (Middle) <u>JOSEPH</u> c. (Last) <u>EADS</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>MARCH 9, 1956</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>APRIL 8, 1920</u>	
9. AGE (In years last birthday) <u>35</u>		If UNDER 1 YEAR Months _____ Days _____		If UNDER 1 Wks. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tool SALTER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Lake City Plant</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>LATHROP - MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Ralph Eads</u>			13b. MOTHER'S MAIDEN NAME <u>ELLA PETERSON</u>		14. NAME OF HUSBAND OR WIFE <u>MAXINE EADS</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WWI No. 2</u>			16. SOCIAL SECURITY NO. <u>497-30-5906</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Maxine Eads</u> ADDRESS <u>LATHROP, MO</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, assthenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>pulmonary thrombosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u>
		ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) _____ rise to the above cause (a) stating the underlying cause last.  DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>chronic tonsillitis, pituitary gland dysfunction, postoperative thrombosis following tonsillectomy</u>					<u>20 yrs</u> <u>35 yrs</u> <u>12 hrs</u>
19a. DATE OF OPERATION <u>3-9-56</u>		19b. MAJOR FINDINGS OF OPERATION <u>chronic tonsillitis &amp; hypertrophy of tonsils</u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <u>5101</u> (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? _____			
22. I hereby certify that I attended the deceased from <u>3-3</u> , 19 <u>56</u> , to <u>3-9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-9</u> , 19 <u>56</u> , and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>R. Wetherston MD</u>				23b. ADDRESS <u>Cameron Mo</u>		23c. DATE SIGNED <u>3-10-56</u>	
24a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>MAR. 12-56</u>		24c. NAME OF CEMETERY OR CREMATORY <u>LATHROP CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>LATHROP MO.</u>	
DATE REC'D BY LOCAL REG. <u>APR. 13-56</u>		REGISTRAR'S SIGNATURE <u>Winifred W. Moser</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>DeWoss CRUNK</u>		ADDRESS <u>Cameron, MO</u>	

MAR 2 1918

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 *Laurence J. Thompson*

Licensed Embalmer No. *473*

P. O. Address *Cameron,*

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.