. Health,
& Welfare
. Public
h Service

S. 300
. 1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED SEP 26 1957

STATE FILE NUMBER 33461

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8775

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: ST. LOUIS, MO. Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): ST. LOUIS CITY HOSP. #1. Length of stay in Ib

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY
c. CITY OR TOWN: St. Louis, Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 2632a Shenandoah Ave. Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First JOHN Middle HENRY Last ESKEW
4. DATE OF DEATH: Month SEPT. Day 16 Year 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-15-1883
9. AGE (In years last birthday): 73 IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (City and state or country): Warren Co. Ky.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME: Joseph H. Eskew
13b. MOTHER'S MAIDEN NAME: Laura Ann Strong
14. NAME OF HUSBAND OR WIFE:
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Della Mae Jones, Address St. Louis, Mo.

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ENCEPHALOMALACIA OF THE LATERAL
ASDECES OF FRONTAL, TEMPORAL, + PARIETAL
LOBES OF THE ⊙ CEREBRAL HEMISPHERE
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. ~~DUE TO (b)~~
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): ASPIRATION PNEUMONIA 332X
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 9/12/57, to 9/16/57 and last saw her/him alive on 9/16/57
Death occurred at 8:30 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: R. M. Wadsley M. D. (Degree or title)
22b. ADDRESS: 1515 LAFAYETTE AVE.
22c. DATE SIGNED: 9/16/57

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 9-18-1957
23c. NAME OF CEMETERY OR CREMATORY: Bladgett Cemetery
23d. LOCATION (City, town, or county) (State): Bladgett, Missouri

24. FUNERAL DIRECTOR: McLaughlin's ADDRESS: 2301 Lafayette
25. DATE RECD. BY LOCAL REG.: SEP 18 57
26. REGISTRAR'S SIGNATURE: J Earl Smith MD
MJB.

(Licensed Embalmer's Statement on Reverse Side)

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 ..... Signed James M. Chapman

Signature of Student Embalmer

Licensed Embalmer No. 7550

P. O. Address St. Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.