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FILED FEB 28 1958

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-007170
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1637

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS Mo — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 4420 Pennsylvania — Length of stay in 1b: 0/

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): 4420 Pennsylvania — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First / Middle / Last: MARTHA M. MUNIE-EASTBURN

4. DATE OF DEATH: Month FEB. Day 11 Year 1958

5. SEX: Female
6. COLOR OR RACE: WHITE
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: SEPT 1 1899
9. AGE (In years last birthday): 58 — 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): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: AT Home
11. BIRTHPLACE (City and state or country): ILLINOIS
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: JOSEPH CHATELION
13b. MOTHER'S MAIDEN NAME: UNKNOWN
14. NAME OF HUSBAND OR ~~WIFE~~: WILLIAM EASTBURN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: WILLIAM EASTBURN — Address: 4420 Pennsylvania

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Hypertensive A-S CVR Dis — 10 yrs
DUE TO (c) Hemiplegia — 2
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 442x

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑ 2

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 12-27-57 to 2-10-58 and last saw her alive on 2-7-58
Death occurred at 1:20 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: C A Nester MD (Degree or title)
22b. ADDRESS: 560 S Compton
22c. DATE SIGNED: 2-11-58

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
23b. DATE: Feb. 14 1958
23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City, town, or county) (State): TRENTON ILL

24. FUNERAL DIRECTOR: Thomas Kutes — ADDRESS: 2906 Gravois
25. DATE RECD. BY LOCAL REG.: FEB 11 '58
26. REGISTRAR'S SIGNATURE: J Carl Smith MD
MJB

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in filling in items 18a-18c. No symptoms, modes of dying, or conditions of birth may be used.
All diseases in Part I must be causally related.

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 Homer C Dill

Licensed Embalmer No. 4347

P. O. Address 2906 Shawn

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.