

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010419
STATE FILE NUMBER

FILED APR 8 1959 Registration District No. 275 Primary Registration District No. 3053 Registrar's No. 53

300
1-57

1. PLACE OF DEATH a. COUNTY Phelps		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Dent	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rolla		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Rural- Franklin Twp. 6 3.30
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Phelps Co. Memo.		Length of stay in lb 6 days	d. STREET ADDRESS Rte 5 (If outside, give location) Darien, Mo.
Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last ERNEST SAMUEL EADS			4. DATE OF DEATH Month Day Year March 29 1959		
--	--	--	---	--	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 28 1896	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
----------------	---------------------------	---	----------------------------------	---------------------------------------	---	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor (ret)	10b. KIND OF BUSINESS OR INDUSTRY Liquor Bar	11. BIRTHPLACE (City and state or country) Glen Carbon, Illinois	12. CITIZEN OF WHAT COUNTRY? USA
---	---	---	-------------------------------------

13a. FATHER'S NAME John J. Eads	13b. MOTHER'S MAIDEN NAME Katherine Parks	14. NAME OF HUSBAND OR WIFE Gladys George Eads
------------------------------------	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. 375-12-6604	17. INFORMANT Gladys Eads	Address Rte 5 Salem, Mo.
---	--	------------------------------	-----------------------------

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 Vascular Accident		INTERVAL BETWEEN ONSET AND DEATH 30 Hours
DUE TO (b) Arteriosclerosis - Senescent 2 years		
DUE TO (c) 331X		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Glomerulo nephritis & Uremia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---	--

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	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 3/23/59 to 3-29-59 and last saw him alive on 3-29-59 Death occurred at 5:20 P m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE Wm. J. [Signature] D.O.	(Degree or title)	22b. ADDRESS Rolla Mo	22c. DATE SIGNED 3/30/59
---	-------------------	--------------------------	-----------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Mar 31 1959	23c. NAME OF CEMETERY OR CREMATORY Cedar Grove Cemetery	23d. LOCATION (City, town, or county) (State) Salem Missouri
--	--------------------------	--	---

24. FUNERAL DIRECTOR Max L. Warfel	ADDRESS Salem, Mo.	25. DATE RECD. BY LOCAL REG. Mar. 30, 1959	26. REGISTRAR'S SIGNATURE Nadine L. Stoll
---------------------------------------	-----------------------	---	--

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

APR 8 1959

MAY 8 1959

APR 9 1959

JUN 8 1959

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 Max L. Warfel

Licensed Embalmer No. 4170

P. O. Address Salem, 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.