

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019119

STATE FILE NUMBER

FILED JUN 1 1959

Registration District No.

Primary Registration District No.

Registrar **2** 4916

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|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY City of St. Louis | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Arkansas b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Hope, Arkansas |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Prisco Employees Hospital Association | | Length of stay in 1b | d. STREET ADDRESS (If outside, give location) 320 South Elm |
| | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|--|----------------------------------|---|---|---|--|--------------------------------|--------------------------------|
| 3. NAME OF DECEASED (Type or print) First Harry Middle L Last Eaton | | | 4. DATE OF DEATH Month 5 Day 19 Year 59 | | | | |
| 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 August 13, 1895 | | 9. AGE (In years last birthday) 63 | 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) Agent | | 10b. KIND OF BUSINESS OR INDUSTRY Railroad | 11. BIRTHPLACE (City and state or country) Waco, Texas. | | 12. CITIZEN OF WHAT COUNTRY? United States | | |
| 13a. FATHER'S NAME Harry E. Eaton | | 13b. MOTHER'S MAIDEN NAME Eleanora Lynn | | 14. NAME OF HUSBAND OR WIFE Ollie | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W. W. #1 | | 16. SOCIAL SECURITY NO. 702-07-0091 | 17. INFORMANT Address Mrs. O. Eaton, 320 So. Elm, St. Hope, Arkansas | | | | |

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|---|---|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous Cell Carcinoma from Pyriform Sinus with Metastases and Tracheal-Pharangeal Obstruction | | INTERVAL BETWEEN ONSET AND DEATH Sept. 1958 |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Tracheostomy - Tracheotomy | |
| | DUE TO (c) Tracheotomy 147x | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | 19. WAS AUTOPSY PERFORMED? / YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |

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|---|--|--|
| 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. | | |

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|--|--|--|---|------------------------------------|
| 20d. INJURY OCCURRED WHILE AT WORK <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 Garland, Texas. | COUNTY | STATE |
| 21. I attended the deceased from Feb. 17, 1959 to May 19, 1959 and last saw her alive on May 19, 1959 Death occurred at 10:10 A.M. on the date stated above; and to the best of my knowledge, from the causes stated. | | | | |
| 22a. SIGNATURE W. W. #1 | | (Degree or title) | 22b. ADDRESS 4960 Laclede, St. Louis, Mo. | 22c. DATE SIGNED 5-19-59 |

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|---|-----------------------------|--|---|---------|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 5-20-59 | 23c. NAME OF CEMETERY OR CREMATORY Local | 23d. LOCATION (City, town, or county) Garland, Texas. | (State) |
|---|-----------------------------|--|---|---------|

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|---|---------|---|--|
| 24. FUNERAL DIRECTOR Albert H. Hoppe 4700 Washington, Bldg. | ADDRESS | 25. DATE RECD. BY LOCAL REG. MAY 20 '59 | 26. REGISTRAR'S SIGNATURE Earl Smith, M.D. |
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 Edmond H. Remelick

Licensed Embalmer No. 4283

P. O. Address St. Louis

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.