

**FEDERAL BUREAU OF INVESTIGATION - U.S. DEPARTMENT OF JUSTICE**  
**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS NOV 16 1959

59-038377

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 2983

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond Heights, Mo.</u>		Length of stay in 1b <u>9 hours</u>	c. CITY OR TOWN <u>Flordell Hills</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>5724 Gaylord Drive</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Herbert</u> Middle <u>L.</u> Last <u>Eaves.</u>			4. DATE OF DEATH Month <u>November</u> , Day <u>7</u> , Year <u>1959.</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-23-1902</u>	9. AGE (last birthday) <u>57</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Mechanic</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Consolidated Fwd. Co.</u>	11. BIRTHPLACE (City and state or country) <u>Dongala, Ill.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Andrew Eaves</u>	13b. MOTHER'S MAIDEN NAME <u>Ara Mull</u>	14. NAME OF HUSBAND OR WIFE <u>Mrs Iva Eaves.</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>377-09-9187</u>	17. INFORMANT Address <u>Mrs Iva Eaves, 5724 Gaylord Drive</u>
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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) <u>Arteriosclerosis of the Aorta</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>  </u>	
	DUE TO (c) <u>  </u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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.)
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20c. TIME OF INJURY Hour, a.m. or p.m. <u>  </u> Month, Day, Year <u>  </u>	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 COUNTY STATE
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21. I attended the deceased from <u>11-7-59</u> to <u>11-7-59</u> and last saw her/him alive on <u>11-7-59</u> . Death occurred at <u>9:00 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) <u>John C. Murphy M.D.</u>	22b. ADDRESS <u>30 Sedgemoor</u>	22c. DATE SIGNED <u>11-9-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>11-11-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Blairsville Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Blairsville, Illinois</u>
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24. FUNERAL DIRECTOR <u>MOTOR</u> ADDRESS <u>Math. Hermann &amp; Son INC. 2161 E. Fair Ave.</u>	25. DATE RECD. BY LOCAL REG. <u>11-10-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Clement McQuay

Licensed Embalmer No. 373

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.