

Dept. Health,  
c. & Welfare  
S. Public  
Health Service

FILED VS JUN 16 1960

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

=60-022234

STATE FILE NUMBER

Registration District No. 13 Primary Registration District No. 3003 Registrar's No. 74

V. S. 300  
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <u>Barry</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Lawrence</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Monett</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Pierce City 25502</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>Scroggins Rest Home</u>		Length of stay in lb <u>86</u>	d. STREET ADDRESS (If outside, give location) <u>East Commercial</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Caleb Lee Eaker</u>			4. DATE OF DEATH Month Day Year <u>6 7 1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/16/1878</u>		9. AGE (In years last birthday) <u>82</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Lutesville, Mo.</u>	
10c. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Caleb Eaker</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Broner</u>	
14. NAME OF HUSBAND OR WIFE <u>Ethel Eaker</u>		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>498-24-4477</u>	
17. INFORMANT <u>Chester Eaker</u>		Address <u>Edwardsville, Ill</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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>St. Hypostatic pneumonia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Case of pneumonia &amp; peritonitis 10/16/59</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
DUE TO (c) <u>199.2</u>					
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 <u>9-22-59</u> to <u>6-7-60</u> and last saw her alive on <u>6-6-60</u> Death occurred at <u>3:30 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (If free or title) <u>Charles Moore D.O.</u>			22b. ADDRESS <u>Pierce City Mo</u>		22c. DATE SIGNED <u>6-7-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>June 9, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Harvey</u>		23d. LOCATION (City, town, or county) (State) <u>Lutesville, MO.</u>
24. FUNERAL DIRECTOR <u>Wm. J. Wessell</u>			ADDRESS <u>Pierce City, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>6-7-60</u>	26. REGISTRAR'S SIGNATURE <u>Mrs P.N. Cook</u>

securing the medical certification in the specific manner required by 193.140 MoRS 1949.  
 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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION

2-0

Rec. 6-15-60

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 *J. D. Buchanan* .....

Licensed Embalmer No. *3149* .....

P. O. Address *Monett, 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.