

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-042549

FILED VS NOV 17 1960

Registration District No. 163 Primary Registration District No. 3031 Registrar's No. 67

STATE FILE NUMBER

NDED

1. PLACE OF DEATH a. COUNTY <u>JEFFERSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>JEFF</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>DE SOTO</u>		Length of stay in lb <u>30 YRS.</u>		c. CITY OR TOWN <u>DE SOTO</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>912 N. SECOND</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>912 N. SECOND</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>CALLIE DEARING EAVES</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>4</u> Year <u>1960</u>									
5. SEX <u>FEMALE</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>3-15-1878</u>		9. AGE (last birthday) <u>82</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>***</u>		11. BIRTHPLACE (City and state or country) <u>BELLFONTAINE, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13a. FATHER'S NAME <u>HENRY DEARING</u>				13b. MOTHER'S MAIDEN NAME <u>CASSANDRA BLACKWELL</u>				14. NAME OF HUSBAND OR WIFE <u>H. T. EAVES</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>NONE</u>		17. INFORMANT <u>H. T. EAVES 912 N. SECOND</u>							
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>Carcinoma of right breast, with carcinomatosis (untreated)</u>										INTERVAL BETWEEN ONSET AND DEATH <u>8-10 years</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)													
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					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 a.m. p.m.		Month, Day, Year											
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					
21. I attended the deceased from <u>Oct 1, 1960</u> to <u>Nov 4, 1960</u> and last saw her alive on <u>Nov 4, 1960</u> Death occurred at <u>7:55 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>Thomas A. Donnell M.D.</u>						22b. ADDRESS <u>DeSoto, Mo</u>			22c. DATE SIGNED <u>11-6-60</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>Nov. 6, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HILLSBORO</u>		23d. LOCATION (City, town, or county) <u>HILLSBORO, Mo.</u>		(State)					
24. FUNERAL DIRECTOR <u>DIETRICH FUNERAL HOME</u>				ADDRESS <u>DE SOTO, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>Nov. 6-1960</u>		26. REGISTRAR'S SIGNATURE <u>Marie Harris</u>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 20 1960

NOV 17 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Donnell B. Smith

Licensed Embalmer No. 4104

P. O. Address Delato Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.