

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN University City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Luke's Hospital		d. STREET ADDRESS (If outside, give location) 1226 Purdue Ave.	

3. NAME OF DECEASED (Type or print) First PAUL Middle BELMONT Last EASON	4. DATE OF DEATH Month Dec. Day 30 Year 1960
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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 3-12-1904	9. AGE (last birthday) 56	IF UNDER 1 YEAR Months 5 Days 12	IF UNDER 24 HR Hours 12 Min. 00
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ass't. Sup't.-American Refrigerator Transit Co.	10b. KIND OF BUSINESS OR INDUSTRY St. Louis, Mo.	11. BIRTHPLACE (City and state or country) U.S.A.	12. CITIZEN OF WHAT COUNTRY
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13a. FATHER'S NAME Alba Eason	13b. MOTHER'S MAIDEN NAME Carrie Norris	14. NAME OF HUSBAND OR WIFE Verda Eason
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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) No	16. SOCIAL SECURITY NO. 702-09-0471	17. INFORMANT Verda Eason Address 1226 Purdue Ave.
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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) Pulmonary embolism		INTERVAL BETWEEN ONSET AND DEATH 5 minutes
DUE TO (b) Adenocarcinomas of rectum		3 months
DUE TO (c) 154 X		

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 checked="" 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.)
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20c. TIME OF INJURY Hour 11:35 P. Month, Day, Year Mar 10, 1956	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 St. Louis COUNTY St. Louis STATE Mo.
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21. I attended the deceased from Mar 10, 1956 to 12-30-60 and last saw him alive on 12-30-60 Death occurred at 11:35 P. on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE James B. Jones M.D. (Degree or title)	22b. ADDRESS 9313 Manchester Road St. Louis 19, Mo.	22c. DATE SIGNED 12-31-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Jan. 3, 1961	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
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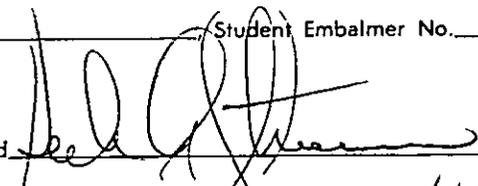
24. FUNERAL DIRECTOR Kriegshauser ADDRESS 9450 Olive St. Road	25. DATE RECD. BY LOCAL REG. JAN 2 1961	26. REGISTRAR'S SIGNATURE Paul Smith M.D.
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DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed  _____
Licensed Embalmer No. 4533

P. O. Address _____

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.