

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-000736

FILED VS JAN 23 1961 87

Registration District No. _____ Primary Registration District No. 4565 Registrar's No. 3

STATE FILE NUMBER

WRITE
STUB

AMENDED

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59

DATE AMENDED

812

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

TYPEWRITER RIBBON

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | | | | | |
|---|--|---|--|--|--|--|---|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | | |
| a. COUNTY | | CRAWFORD | | a. STATE | | MISSOURI | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) | | SULLIVAN | | b. COUNTY | | CRAWFORD | |
| Length of stay in 1b | | 15 Mos. | | c. CITY OR TOWN | | SULLIVAN | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION | | FAIR AVE. (REAR) | | d. STREET ADDRESS (If outside, give location) | | FAIR AVE (REAR) | |
| Inside Limits | | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm | | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | | | 4. DATE OF DEATH | | | |
| First | | Middle | | Last | | Month Day Year | |
| JULIA | | VICTORIA | | MAY | | EASTER | |
| JAN | | 18 | | 1961 | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH | |
| FEMALE | | WHITE | | MAY 7 1892 | | 78 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) | | 12. CITIZEN OF WHAT COUNTRY | |
| HOUSEWIFE | | | | OZARK CO. MO. | | U.S.A. | |
| 13a. FATHER'S NAME | | 13b. MOTHER'S MAIDEN NAME | | 17. NAME OF HUSBAND (Give name and address) | | | |
| JOSEPH MITCHELL | | JANE WHITE | | JOHN B. EASTER | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | |
| No | | NONE | | JOHN B. EASTER, SULLIVAN, MO. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) | | | | | | | MONTHS |
| DUE TO (b) | | | | | | | YEARS |
| 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. |
| ADDISON'S DISEASE | | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 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.) | | | |
| 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 | | 1959 | | to JAN 2 1961 | | and last saw her alive on JAN 18 1961 | |
| Death occurred at | | 11:45 | | P. | | m on the date stated above, and to the best of my knowledge, from the causes stated. | |
| 22a. SIGNATURE (Degree or title) | | 22b. ADDRESS | | 22c. DATE SIGNED | | | |
| Robert M. Eaton M.D. | | Sullivan Mo. | | Jan 19 61 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) (State) | |
| BURIAL | | JAN 22 1961 | | I.O.O.F. MEMORIAL CEM | | SULLIVAN MO. | |
| 24. FUNERAL DIRECTOR ADDRESS | | 25. DATE RECD. BY LOCAL REG. | | 26. REGISTRAR'S SIGNATURE | | | |
| H.M. EATON, SULLIVAN, MO. | | Jan 20 1961 | | [Signature] | | | |

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 Harrison Jr. Eaton

Licensed Embalmer No. 5066

P. O. Address Sullivan, Md.

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.