

DATE AMENDED

INSTEAD OF DOCUMENT

SHOULD READ BY AFFIDAVIT OF

1. PLACE OF DEATH
 a. COUNTY
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **ST LOUIS MISSOURI** Length of stay in 1b **38 DAYS**
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **VETERANS ADMIN HOSPITAL** Inside Limits Yes No
 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE **TENNESSEE**. COUNTY
 c. CITY OR TOWN **DRESDEN** Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First **ERIC** Middle **NMI** Last **DEW** 4. DATE OF DEATH Month **1-11-61** Day Year
 5. SEX **MALE** 6. COLOR OR RACE **NEGRO** 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH **11-21-92** 9. AGE (last birthday) **68**
 IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **UNK** 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (City and state or country) **TENN.** 12. CITIZEN OF WHAT COUNTRY **USA**
 13a. FATHER'S NAME **SAMUEL DEW** 13b. MOTHER'S MAIDEN NAME **MALICE WHITE** 14. NAME OF HUSBAND OR WIFE
 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **YES** (If yes, give year or dates of service) **WWI** 16. SOCIAL SECURITY NO. 17. INFORMANT **THOMAS DEW 1946a Burel St. St. Louis, Mo.** Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) **HEPATIC ENCEPHALOPATHY** INTERVAL BETWEEN ONSET AND DEATH **3 DAYS**
 DUE TO (b) **FAENNEE'S CIRRHOSIS**
 DUE TO (c) **581.1**
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) **ARTERIOSCLEROTIC HEART DISEASE**
 PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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
 20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 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 **VA 12-5-60** to **1-11-61** and was **responsible** for his care until he died on **1-11-61**
 Death occurred at **5:55 PM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **John C. Hogan, M.D.** 22b. ADDRESS **VA HOSPITAL 915 NO. GRAND ST. LOUIS, MO.** 22c. DATE SIGNED **1-11-61**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 23b. DATE **1-14-61** 23c. NAME OF CEMETERY OR CREMATORY **Fulton Kentucky** 23d. LOCATION (City, town, or county) (State) **Fulton, Kentucky**

24. FUNERAL DIRECTOR **G. Wade Granberry** ADDRESS **4202 Finney Ave.** 25. DATE RECD. BY LOCAL REG. **JAN 12 1961** 26. REGISTRAR'S SIGNATURE **Joan Smith, M.D.**

JAN 9 8 1961

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

Edward A. Flynn

Licensed Embalmer No. 4444

P. O. Address 4202 Finney Ave.

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.