

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

8761

-61-034250

STATE FILE NUMBER

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

DATE AMENDED

INSTEAD OF THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED SEP 27 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 3 days	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Johns Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3024 Rolla Place
		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Conrad Middle S. Last Eaton	4. DATE OF DEATH Month 9 Day 20 Year 61
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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 5/4/89	9. AGE (last birthday) 72	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Streetcar Operator-Ret.	10b. KIND OF BUSINESS OR INDUSTRY St.L.Public Svc.	11. BIRTHPLACE (City and state or country) Warren County, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME William Eaton	13b. MOTHER'S MAIDEN NAME Rosana Karwise	14. NAME OF HUSBAND OR WIFE Sarah O. Eaton
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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	17. INFORMANT Mrs. Sarah O. Eaton, 3024 Rolla Pl.
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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) Myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH 5 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerotic heart disease	
	DUE TO (c) 420.0	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) General Arteriosclerosis	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 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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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
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21. I attended the deceased from 9-17-61 to 9-20-61 and last saw ^{her} him alive on 9-20-61 Death occurred at 4:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE Loan Penland, M.D. (Degree or title)	22b. ADDRESS 18-S. Kingshighway	22c. DATE SIGNED 9-21-61
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23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 9/23/61	23c. NAME OF CEMETERY OR CREMATORY Wright City Cemetery	23d. LOCATION (City, town, or county) (State) Wright City Mo.
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24. FUNERAL DIRECTOR Drehmann-Harral	ADDRESS 1905 Union	25. DATE RECD. BY LOCAL REG. SEP 21 1961	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.
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DR. CARL J. NEIS
18 So. Kingshighway
No. 1-0150

Hrs. 10:30 - 12 noon Thurs.

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 Warren A. Carver

Licensed Embalmer No. 353X

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.