

SOURCE DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-81-042374

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10745**

STATE FILE NUMBER

AMENDED

FILED DEC 1 1961

DATE AMENDED

1. PLACE OF DEATH a. COUNTY <i>Saint Louis</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Saint Louis County</i>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <i>Saint Louis</i>		Length of stay in 1b <i>26 days</i>	c. CITY OR TOWN <i>Wellston</i>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>St Johns Hospital</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <i>6319 Isabelle</i>
Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <i>JAMES</i> Middle <i>- William</i> Last <i>EUDALEY</i>	4. DATE OF DEATH Month <i>November</i> Day <i>17</i> Year <i>1961</i>
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5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>11-23-05</i>	9. AGE (last birthday) <i>55</i>	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) <i>mechanic</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Brake Repair</i>	11. BIRTHPLACE (City and state or country) <i>Butler County Mo</i>	12. CITIZEN OF WHAT COUNTRY <i>USA</i>
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13a. FATHER'S NAME <i>John Eudaley</i>	13b. MOTHER'S MAIDEN NAME <i>Loretta Lunn</i>	14. NAME OF HUSBAND OR WIFE <i>none</i>
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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) <i>no</i>	17. INFORMANT <i>Thomas G. Eudaley 8933 Newby</i>	Address _____
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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) <i>Fractured skull and hemorrhage of the anterior lobe of left side, suffered in auto accident in the vicinity of St. Louis, Missouri on or about October 22nd, 1961.</i> DUE TO (b) <i>same as above</i> DUE TO (c) <i>same as above</i>		INTERVAL BETWEEN ONSET AND DEATH _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>OPEN VERDICT.</i>		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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> <i>OPEN VERDICT</i>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <i>See above</i>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. <i>10-22-61</i>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> <i>65 Street</i>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Street</i>	20f. CITY, TOWN, OR LOCATION <i>St Peters, Missouri</i>	COUNTY _____ STATE _____
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Jays in Truman Agency</i>	(Degree or title) _____	22b. ADDRESS <i>1300 Clark</i>	22c. DATE SIGNED <i>11-4-61</i>
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23. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremial</i>	23b. DATE <i>November</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Shiloh Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Willmoreville Mo.</i>
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24. FUNERAL DIRECTOR <i>O'Fallon Mortuary Inc</i>	ADDRESS <i>O'Fallon, Mo.</i>	25. DATE RECD. BY LOCAL REG. <i>NOV 20 1961</i>	26. REGISTRAR'S SIGNATURE <i>Paul Smith M.D.</i>
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INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFRUIT OF

ITEM NO. SHOULD READ

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 *Charles J. Callahan*

Licensed Embalmer No. 5128

P. O. Address O'Fallon,

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.