

FILED JUL 8 1944
Registration District No. 318

Primary Registration District No. 1003

19645
11049
5776

1. PLACE OF DEATH:

(a) County St. Louis MO
(b) City or town St. Louis MO
(c) Name of hospital or institution City Hospital #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: 0 in hospital or institution (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME JEANETTE M EATON

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec 10 1940
(Month) (Day) (Year)

8. AGE: Years 7 Months 6 Days 16 If less than one day hr. _____ min. _____

9. Birthplace St. Louis MO
(City, town, or county) (State or foreign country)

10. Usual occupation infant

11. Industry or business _____

12. Name Wm. Eaton 0

13. Birthplace Steelville MO
(City, town, or county) (State or foreign country)

14. Maiden name Ma. Morrison

15. Birthplace Cherryville MO
(City, town, or county) (State or foreign country)

16. (a) Informant Wm. Eaton

(b) Address 1810 N Jefferson

17. (a) removal (b) Date thereof 6/27/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenman Cemetery

18. (a) Signature of funeral director J. J. Beedeck

(b) JUN 28 1944 (c) J. J. Beedeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County _____
(c) City or town St. Louis MO (If outside city or town limits, write "RURAL")
(d) Street No. 1810 N. Jefferson (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 26
year 1944 hour 11 minute 30 A.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death _____

Pertussis

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place) _____ While at work? _____ (e) Means of injury _____

23. Signature Thomas H. Allen (M. D. or other) _____
Address Deputy Coroner Date signed 6-27-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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 this body is not embalmed, fact should be so stated above.