

FILED AUG 28 1944
Registration District No. **277**

Primary Registration District No. **3069**

Registrar's No. **1738**

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

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **Richmond Heights**
(c) Name of hospital or institution: **St. Marys Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **4 Days**
In this community **4 Days**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **III**
(c) City or town **Piedmont**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

ASA EADS

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

4. Sex **male** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **infant**

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

7. Birth date of deceased **Dec. 11th 1942**
(Month) (Day) (Year)

8. AGE: Years **1** Months **8** Days **4** If less than one day _____ hr. _____ min.

9. Birthplace **Patterson, Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Infant**

11. Industry or business _____

MOTHER FATHER

12. Name **Billie Eads**

13. Birthplace **Piedmont, Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Myrtle Peyton**

15. Birthplace **Patterson, Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Myrtle Eads**

(b) Address **Piedmont, Mo.**

17. (a) **Motor** (b) Date thereof **8/15/44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Piedmont, Mo.**

18. (a) Signature of funeral director **A. W. McLaughlin**
(b) Address **2301 Lafayette Ave**

19. (a) **AUG 18 1944** (b) **E. G. McSavaran, M.D.**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **15** year **1944** hour **5** minute **05 A.** M.

21. I hereby certify that I attended the deceased from **Aug 10** 19**44** to **Aug 15** 19**44** that I last saw him alive on **Aug 14** and that death occurred on the date and hour stated above.

Immediate cause of death **Inanition**
Marasmus
Diarrhea

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **119 a 2**

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? _____

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

23. Signature **Jackson Eto** (M. D. or _____) Address **650 Clayton Rd** Date signed **8/15/44**

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 L. R. Cooper
Licensed Embalmer No. 3637
P. O. Address 2317 Lafayette

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.