

FILED NOV 4 1944

Registration District No. 376

Primary Registration District No. 6075

Registrar's No. 180

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Farmington RURAL St. Francois
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mo. State Hospital No. 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 hrs. 25 min.
(Specify whether

In this community _____
years, months or days)

3. (a) PRINT FULL NAME ORA EATON

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

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

6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive About 1907 years

7. Birth date of deceased. About 1907
(Month) (Day) (Year)

8. AGE: Years About 37 Months _____ Days _____ If less than one day hr. _____ min. _____

9. Birthplace Carter Co., Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farming and common labor.

11. Industry or business _____

MOTHER FATHER { 12. Name Wes Eaton (?)
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Records State Hospital No. 4

(b) Address Farmington, Missouri

17. (a) Burial (b) Date thereof 8-8-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Carson Hill Cem., Millspring, Mo.

18. (a) Signature of funeral director Gish Funeral Service

(b) Address Piedmont, Missouri

19. (a) 10-24-44 (b) Josiah Perkins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Carter 94
(c) City or town Ellsinore
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 6
year 1944 hour 12 minute 25 P. M.

21. I hereby certify that I attended the deceased from August 5, 1944 19 to August 6, 1944 19;
that I last saw him alive on August 6, 1944 19;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Meningeal Exanthema etc

Due to _____

Due to _____

Other conditions Mental Suffering
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____
Of autopsy No findings

PHYSICIAN

Underline the cause to which death should be charged statistically.

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) (e) Means of injury _____

23. Signature M. J. ... (M. D. or other) med

Address 408 ... Date signed 8-9-44

1373

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

RECEIVED

District Health Officer No. 4
District File Number 1144-4473
Date Filed 11-3-44

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 Bert J Miller

Licensed Embalmer No. 3752

P. O. Address Farmington, Mo.

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.