

S. No. 2
OM-2-43
v. 5-17-39
X35697

24666

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18354

FILED JUN 6 1946

State File No. _____

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 4807

1. PLACE OF DEATH:

(a) County St. Louis, Mo.

(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis City Hospital - Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri County _____

(c) City or town St. Louis 1917
(If outside city or town limits, write "RURAL")

(d) Street No. 3822a Olive 9
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME JULIA EAVES

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex F / 5. Color or race W

6. (a) Single, widowed, married, divorced M /

6. (b) Name of husband or wife Robert H

6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased 3 (Month) 30 (Day) 1880 (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 27th
year 1946 hour 9:50 minute P M.

21. I hereby certify that I attended the deceased from 5-6-46
19. to May 27th 19. 46

that I last saw her alive on May 27th 19. 46
and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory failure Duration _____

Due to Chronic T.B., far advanced

Due to Chronic hepatitis, chronic, acute terminal

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

8. AGE: Years 66 Months 1 Days 27 If less than one day hr. _____ min. _____

9. Birthplace Kansas City, Kansas (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name Blanton

13. Birthplace N. Carolina (City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace N. Carolina (City, town, or county) (State or foreign country)

16. (a) Informant Robert H. Eaves

(b) Address 3822a Olive

17. (a) Burial (b) Date thereof 5/30/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lake Charles

18. (a) Signature of funeral director Edward J. Grand

(b) Address 3710 Grand Blvd.

19. (a) MAY 29 1946 (b) J. F. Bredenk
(Date of death) (Registrar's signature)

Major findings: Of operations _____ Of autopsy _____

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 place of place) Means of injury F

23. Signature LeRoy Stephens 5/28/46
Address 1515 Lafayette Date signed _____

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

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..... *V.E. Morris*

Licensed Embalmer No..... *3360*

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.