

MISSOURI DEPARTMENT OF HEALTH  
STANDARD CERTIFICATE OF DEATH

FILED DEC 2 1948  
Registration District No. 318

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County ST LOUIS  
 (b) City or town ST LOUIS  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Barnes Hospital,  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution three days  
 (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_  
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St. Louis  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 2934 Harper St.  
 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME SAM EUGENE EARSON  
 3. (b) If veteran, name war None 3. (c) Social Security No. 497-01-8148  
 4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Grace 6. (c) Age of husband or wife if alive 55 years  
 7. Birth date of deceased Dec. 30 1886  
 (Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 18  
 year 1948 hour 11:15 minute P M.  
 21. I hereby certify that I attended the deceased from 11-15-48  
 \_\_\_\_\_, 1948 to 11-18, 1948  
 that I last saw him alive on 11-18  
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
61 10 18 hr. min.

Immediate cause of death Cerebral vascular accident Duration \_\_\_\_\_  
 Due to Hypertensive cardio-vascular disease  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

9. Birthplace Clinton Missouri  
 (City, town, or county) (State or foreign country)  
 10. Usual occupation Salesman  
 11. Industry or business Manufacturers Supply  
 12. Name James H. Earson  
 13. Birthplace Missouri  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Anna L. Butts  
 15. Birthplace Missouri  
 (City, town, or county) (State or foreign country)

Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Grace Earson  
 (b) Address 2934 Harper St.  
 17. (a) Burial (b) Date thereof 11/20/48  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Moberly, Missouri  
 18. (a) Signature of funeral director PROVOST UND. CO.  
 (b) Address 3710 N. Grand Blvd.  
 19. (a) NOV 18 1948 (b) J. B. Lesater  
 (Date received by registrar) (Registrar's signature)

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 H. Bradley (M. D. or other) \_\_\_\_\_  
 Address Barnes Hospital Date signed 11/19/48

---

---

**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.....

*Albert Mayfield*

Licensed Embalmer No.....

307 >

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.**