

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **3043**  
Registrar's No. **1132**

FILED FEB 11 1953

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>ILLINOIS</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (to this place) <b>2 DAYS</b>	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Du Bois</b>		d. STREET ADDRESS (If rural, give location) <b>R. R. # 1</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis Children's Hospital</b>		8. DATE OF DEATH (Month) (Day) (Year) <b>1 29 53</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>Randall</b> b. (Middle) <b>Ray</b> c. (Last) <b>EATER</b>		9. AGE (In years last birthday) IF UNDER 1 YEAR Days <b>3</b> IF UNDER 24 HRS. Hours Min.	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married</b>	8. DATE OF BIRTH <b>1-26-53</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Du Quoin - ILL.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13a. FATHER'S NAME <b>HARRY EATER</b>		13b. MOTHER'S MAIDEN NAME <b>FRANCES SETZBORN</b>	
14. NAME OF HUSBAND OR WIFE <b>None</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>R. A. Nussman - 600 S. Kingshighway</b> ADDRESS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Kumistioma</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Cryptosporidium fetus</b>			
DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <b>7701</b>			
22. I hereby certify that I attended the deceased from <b>1-27, 1953</b> to <b>1-29, 1953</b> , that I last saw the deceased alive on <b>1-29, 1953</b> , and that death occurred at <b>1:45 A.M.</b> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <b>Donald G. Johnson M.D.</b>		23b. ADDRESS <b>Children's Hospital</b>	
23c. DATE SIGNED <b>1/30/53</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>1-29-53</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>Local</b>		24d. LOCATION (City, town, or county) (State) <b>Tamaroa, Ill.</b>	
DATE REC'D BY LOCAL REG. <b>JAN 30 1953</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H. Hoppe</b> ADDRESS <b>4700 Washington Blvd.</b>			

(Licensed Embalmer's Statement on Reverse Side)

**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.....

..... Student Embalmer No. ....

working under my personal supervision.

Student .....

Student Embalmer

Signed

*John J. Haines*

Licensed Embalmer No. *4108*

P. O. Address *St Louis, 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.