

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....  
19359  
5371

FILED JUN 10 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. ....

|   |                               |   |  |
|---|-------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>2129</u> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>   |                               | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Deaconess Hospital</u>   |                               | d. STREET ADDRESS (If rural, give location) <u>2 5839 Holly Hills</u>   |  |
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First) <u>George</u> b. (Middle) <u>G.</u> c. (Last) <u>Eubanks</u>   |                               |   | 4. DATE OF DEATH (Month) (Day) (Year) <u>May 27-1953</u> |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>   | 8. DATE OF BIRTH <u>4-6-1891</u>                         |
| 9. AGE (In years last birthday) <u>62</u>   |                               | 10. UNDER 1 YEAR Months   | 10. UNDER 1 YEAR Days                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mo. Insurance Co</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>  |  |
| 11. BIRTHPLACE (City and State or Foreign Country) <u>Benton Ill.</u>   |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>  |  |
| 13a. FATHER'S NAME <u>Charles H. Eubanks</u>  |                               | 13b. MOTHER'S MAIDEN NAME <u>Sarah Mc Fackridge</u>   |  |
| 14. NAME OF HUSBAND OR WIFE <u>Lois Eubanks</u>   |                               |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>  |                               | 16. SOCIAL SECURITY NO. <u>492-01-6072</u>  |  |
| 17. INFORMANT'S SIGNATURE OR NAME <u>George Eubanks</u>   |                               | ADDRESS <u>Grant City Ill.</u>  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.                             |                               |   |  |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerotic Heart Disease</u>  |                               | INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>   |  |
| ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Generalized Arteriosclerosis</u>   |                               | <u>6-8 years</u>  |  |
| DUE TO (c) <u>Nephrosclerosis</u>   |                               | <u>1/2 year</u>   |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>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 checked="" 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) m.  |                               | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                  |  |
| 21f. HOW DID INJURY OCCUR? <u>4200</u>  |                               |   |  |
| 22. I hereby certify that I attended the deceased from <u>May 25, 1953</u> , to <u>May 27, 1953</u> , that I last saw the deceased alive on <u>May 27, 1953</u> and that death occurred at <u>6:15 p.m.</u> , from the causes and on the date stated above. |                               |   |  |
| 23a. SIGNATURE <u>John J. Roth M.D.</u> (Degree or title)   |                               | 23b. ADDRESS <u>634 N. Grand Blvd. St. Louis</u>  |  |
| 23c. DATE SIGNED <u>5/28/53</u>   |                               |   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>5-28-53</u>  |                               | 24b. DATE   |  |
| 24c. NAME OF CEMETERY OR CREMATORY <u>Sunset Hill Cem.</u>  |                               | 24d. LOCATION (City, town, or county) (State) <u>Edwardsville Illinois</u>  |  |
| DATE REC'D BY LOCAL REG. <u>MAY 29 1953</u>   |                               | REGISTRAR'S SIGNATURE <u>Frank Merce</u>  |  |
| FURNERAL DIRECTOR'S SIGNATURE <u>Frank Merce</u>  |                               | ADDRESS <u>Grant City Ill.</u>  |  |

WRITE PLAINLY—USING 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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Charles E. Micec*

Licensed Embalmer No.

*2988*

P. O. Address

*Pravite City, Ia*

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.