

Health
Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED SEP 23 1957

STANDARD CERTIFICATE OF DEATH

34370
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2235

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>NEW JERSEY</u> b. COUNTY <u>CAMDEN</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>GLOUCESTER</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST LOUIS CO HOSPITAL</u>		Length of stay in lb <u>1 day</u>	d. STREET ADDRESS <u>352 50 8TH ST</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Thomas S. Eaves</u>			4. DATE OF DEATH Month <u>9</u> Day <u>6</u> Year <u>57</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1884</u> <u>12-16-1887</u>	9. AGE (In years last birthday) <u>72</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>various</u>	11. BIRTHPLACE (City and state or country) <u>Phil. DELPHIA PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
13. FATHER'S NAME <u>THOMAS A. EAVES</u>			14. MOTHER'S MAIDEN NAME <u>LUCY LORD</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>unk.</u>		16. SOCIAL SECURITY NO. <u>237-05-1960</u>	17. INFORMANT Address <u>CHARLES A. EAVES #18-3RD AVE. MTEPHRAM N.J.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
Conditions, if any, which gave rise to above cause: (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>7201</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>9-6-57</u> to <u>9-6-57</u> and last saw her <u>him</u> alive on <u>9-6-57</u> Death occurred at <u>8:00</u> P m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Robert W. Dinkelspiel</u>			22b. ADDRESS <u>601 So. Brentwood</u>		22c. DATE SIGNED <u>9-7-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>9-8-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST MARYS CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>BELMAUR N. J.</u>
24. FUNERAL DIRECTOR <u>EARL HILLEMANN OVERLAND MO</u>		25. DATE RECD. BY LOCAL REG. <u>9-8-57</u>		26. REGISTRAR'S SIGNATURE <u>Robert W. Dinkelspiel</u>	

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.....
Signature of Student Embalmer

Signed *E. S. Hellenius*.....

Licensed Embalmer No. 350

P. O. Address *Osella*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.