

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

# 59-024192

FILED VS JUL 27 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. 1000 Registrar's No. 741

STATE FILE NUMBER

IDED

|   |  |   |  |  |   |   |  |  |  |
|---|--|---|--|--|---|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Buchanan</u>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u> |   |   |  |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>St. Joseph, Missouri</u>  |  | Length of stay in lb<br><u>2 months</u>   |  | c. CITY OR TOWN <u>Lexington, Missouri</u>   |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   |  |  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>State Hospital #2</u>   |  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  | d. STREET ADDRESS (If outside, give location)<br><u>1622 Lafayette St.</u>  |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>EDGAR</u> Middle <u>LYNN</u> Last <u>EASTHAM</u>  |  |   |  | 4. DATE OF DEATH<br>Month <u>July</u> Day <u>23</u> Year <u>1959</u>   |   |   |  |  |  |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u>       | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>Dec 9, 1882</u>   | 9. AGE (last birthday)<br><u>76</u>   | IF UNDER 1 YEAR<br>Months _____ Days _____                                  | IF UNDER 24 HR<br>Hours _____ Min. _____   |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>City Clerk</u>  |  |   | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (City and state or country)<br><u>Indiana</u>                |   | 12. CITIZEN OF WHAT COUNTRY<br><u>USA</u>  |  |  |
| 13a. FATHER'S NAME<br><u>John Edgar Eastham</u>   |  |   | 13b. MOTHER'S MAIDEN NAME<br><u>Anna Staley</u>                                      |  |   | 14. NAME OF HUSBAND OR WIFE<br><u>Gussie Eastham</u>                        |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |  |   | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>Address<br><u>Records, State Hosp. #2, St. Joseph, Mo.</u> |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:  |  |   |  |  |   |   | INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u>   |  |   |  |  |   |   | <u>Unknown</u>   |  |  |
| DUE TO (b) <u>Hypostatic Pneumonia</u>  |  |   |  |  |   |   | <u>3 weeks</u>   |  |  |
| DUE TO (c) _____  |  |   |  |  |   |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)   |  |   |  |  |   |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ a.m. _____ p.m.   |  | Month, Day, Year _____  |  |  |   |   |  |  |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/><br>NOT WHILE AT WORK <input type="checkbox"/>   |  | 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>7-15-59</u> to <u>7-22-59</u> and last saw <sup>her</sup> / <sub>him</sub> alive on <u>July 22, 1959</u><br>Death occurred at <u>8:45 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |  |  |   |   |  |  |  |
| 22a. SIGNATURE (Degree or title)<br><u>M. Tahir, M.D.</u>   |  |   |  | 22b. ADDRESS<br><u>State Hosp. #2, St. Joseph, Mo.</u>   |   |   |  | 22c. DATE SIGNED<br><u>7-23-59</u>                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>   |  | 23b. DATE<br><u>July 23, 1959</u>   | 23c. NAME OF CEMETERY OR CREMATORY   |  |   | 23d. LOCATION (City, town, or county) (State)<br><u>Lexington, Missouri</u> |  |  |  |
| 24. FUNERAL DIRECTOR<br><u>Hester Bowman</u>  |  |   |  | ADDRESS<br><u>St. Joseph, Missouri</u>   |   | 25. DATE RECD. BY LOCAL REG.<br><u>July 23, 1959</u>                        |  | 26. REGISTRAR'S SIGNATURE<br><u>Ms. Clark Godell</u> |  |

DOCUMENT

M. Tahir, M.D. MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

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 embalmed by a STUDENT, he also must sign in his OWN HAND.  
If this body is not embalmed, fact should be so stated above.

*[Handwritten signature]*