

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-012543

FILED VS APR 4 1960

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STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		Length of stay in 1b 18 Years	c. CITY OR TOWN ST. LOUIS Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 2806 No. Taylor COMUNITY HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 952, MARYVILLE Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last GENEVA LUCILLE EASON			4. DATE OF DEATH Month Day Year 3 / 23rd / 1960		
5. SEX FEMALE	6. COLOR OR RACE COL.	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/25/1915	9. AGE (last birthday) 44	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTICTS	11. BIRTHPLACE (City and state or country) FREDRICKTOWN MISSOURI		12. CITIZEN OF WHAT COUNTRY U.S.A
13a. FATHER'S NAME JOHN CARTER MERIDITH		13b. MOTHER'S MAIDEN NAME MARY MARIE MADISON		14. NAME OF HUSBAND OR WIFE FRED EASON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO NONE		16. SOCIAL SECURITY NO. 498-26-5963		17. INFORMANT Address Fred Eason, 952, MARYVILLE	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Cerebral Vascular Accident		1 hour
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Hypertensive Cardiovascular Disease	Unknown
	DUE TO (c) Acute Pulmonary Edema	1 hour
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 443X		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

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 WORK? <input type="checkbox"/> 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 **March 16, 1960** to **March 23, 1960** and last saw her/him alive on **March 23, 1960**
Death occurred at **10:30 pm** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Leslie J. Bond M.D.		22b. ADDRESS 5801st Easton Ave, St. Louis, Mo	22c. DATE SIGNED 3/25/60
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 3-28-1960	23c. NAME OF CEMETERY OR CREMATORY WASHINGTON PARK CEMETERY	23d. LOCATION (City, town, or county) (State) ST. LOUIS, MISSOURI
24. FUNERAL DIRECTOR Estelle White	ADDRESS 2616, No. GARRISON	25. DATE RECD. BY LOCAL REG. MAR 26 1960	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.

DOCUMENT

MEDICAL CERTIFICATION

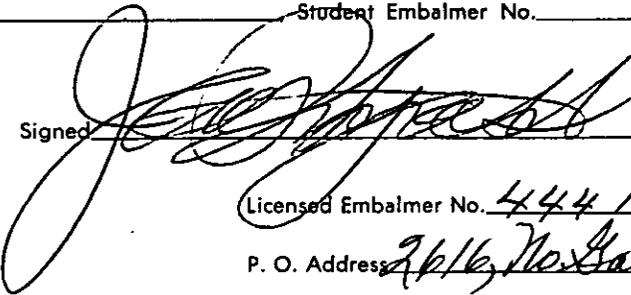
BY AFFIDAVIT OF

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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. 4441

P. O. Address 2616 No. 4th

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 shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.