

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUN 27 1960

318

1003

Registrar's No. 5958

-60-024467

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 5958

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	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 St. Johns Hosp		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2820 St. Vincent
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Martha Middle Elizabeth Last Eason	4. DATE OF DEATH Month June Day 9 Year 1960
--	---

5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/23/84	9. AGE (last birthday) 76	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
----------------------	-------------------------------	---	---------------------------------	----------------------------------	---	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Tenn.	12. CITIZEN OF WHAT COUNTRY USA
---	--	--	---

13a. FATHER'S NAME Robert Kennedy	13b. MOTHER'S MAIDEN NAME Millie Devore	14. NAME OF HUSBAND OR WIFE Lester Eason
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. none	17. INFORMANT Address Robert Eason 2820 a St. Vincent
---	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis	INTERVAL BETWEEN ONSET AND DEATH 3 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Essential Hypertension	15 years
DUE TO (c) 33.2+	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hypothyroidism	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 _____ a.m. _____ p.m. Month, Day, Year _____

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 April 1949 to June 1960 and last saw her alive on June 9, 1960 Death occurred at 1 10 A on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) Martha W. Davis, MD	22b. ADDRESS 539 N. Grand	22c. DATE SIGNED 6/10/60
--	-------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6/11/60	23c. NAME OF CEMETERY OR CREMATORY Doe Creek	23d. LOCATION (City, town, or county) (State) Scotts Hill Tenn.
---	-----------------------------	--	---

24. FUNERAL DIRECTOR ADDRESS E.J. Schnur 3125 Lafayette	25. DATE RECD. BY LOCAL REG. JUN 10 1960	26. REGISTRAR'S SIGNATURE Roan Smith, M.D.
---	--	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

mjs

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 Thomas R. Fenwick

Licensed Embalmer No. 3793

P. O. Address 3125 Lafayette

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.