

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-007823**

FILED VS MAR 2 1960 316

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. 77

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>St., Francois</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Francois</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Desloge, Mo.</b>	Length of stay in 1b <b>75 yrs</b>	c. CITY OR TOWN <b>Desloge</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>5th Street</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5th Street</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Porter</b> Last <b>Eaton</b>	4. DATE OF DEATH Month <b>Feb</b> Day <b>23</b> Year <b>1960</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2-16-1876</b>	9. AGE (last birthday) <b>84</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>St. Joe Lead Co.</b>	11. BIRTHPLACE (City, and state or country) <b>Green County, Ind.</b>	12. CITIZEN OF WHAT COUNTRY <b>US</b>
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13a. FATHER'S NAME <b>Aaron Eaton</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah Hays</b>	14. NAME OF HUSBAND OR WIFE <b>Eugenia Carloine</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>490-03-3765</b>	17. INFORMANT Address <b>Mrs. Sarah French, Bonne Terre, Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arteriosclerotic heart disease</b>	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriosclerotic syndrome at foot</b>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____
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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
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21. I attended the deceased from **June 1957** to **Feb 23, 1960** and last saw him alive on **Feb 23, 1960**  
Death occurred at **8:15 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>J. L. Foster</b> (Degree or title) <b>MC</b>	22b. ADDRESS <b>Desloge, Mo.</b>	22c. DATE SIGNED <b>25 Feb 60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Feb 26, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Marvin Chapel</b>	23d. LOCATION (City, town, or county) (State) <b>St. Francois Mo.</b>
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24. FUNERAL DIRECTOR ADDRESS <b>C. Z. Boyer &amp; Son, Inc. Desloge, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>Feb. 26, 1960</b>	26. REGISTRARS SIGNATURE <b>Eithen Rudloff</b>
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DOCUMENT

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 Burlin T. Boyer, Jr., Student Embalmer No. 599

working under my personal supervision.

Student Burlin T. Boyer, Jr.  
Signature of Student Embalmer

Signed B. T. Boyer

Licensed Embalmer No. 3660

P. O. Address DESLORE, 1770

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