No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 264

FILED FEB 27 1944

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 274

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis City Hospital Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED: 000
(a) State Missouri (b) County 17
(c) City or town St.Louis
(If outside city or town limits, write "RURAL") 23
(d) Street No. 2327 ~~3727~~ S 3rd St.
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Emma Eaves

3. (b) If veteran, name war No
3. (c) Social Security No. No

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Solomon E.Eaves
6. (c) Age of husband or wife if alive years
7. Birth date of deceased May 27 1864 (Month) (Day) (Year)

8. AGE: Years 79 Months 7 Days 9 If less than one day hr. min.

9. Birthplace Irondale (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Nathan Chamberlain
13. Birthplace (City, town, or county) N.Carolina (State or foreign country)

MOTHER
14. Maiden name Mary Minck
15. Birthplace (City, town, or county) Pennsylvania (State or foreign country)

16. (a) Informant Charles Eaves
(b) Address 915 Ann Ave,
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-9-44 (Month) (Day) (Year)
(c) Place: burial or cremation Flat River, Mo.
18. (a) Signature of funeral director Albert H.Hoppe Inc.
(b) Address 4700 Washington Blvd.
19. (a) JAN 11 1944 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 6 year 1944 hour 10:35 minute P M.

21. I hereby certify that I attended the deceased from December 30, 1943 to January 6, 1944; that I last saw her alive on January 6, 1944; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic bronchitis	
Due to	
Due to	
Other conditions arteriosclerotic cardiovascular disease (Include pregnancy within 3 months of death)	

Major findings:
Of operations none
Of autopsy none

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature Leo J. Wade (M. D. or other)
Address 1515 Lafayette Avenue Date signed 1/7/44

(Licensed Embalmer's Statement on Reverse Side)

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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 me, or by..

...., Registered Apprentice No..................................

working under my personal supervision.

Signed Albert G. Hoffe

Licensed Embalmer No. 2971

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 this body is not embalmed, fact should be so stated above.