

FILED APR 24 1969

DEPARTMENT OF PUBLIC HEALTH AND WELFARE - MISSOURI DIVISION OF HEALTH  
(PHYSICIAN OR CORONER)

STATE FILE NUMBER

## CERTIFICATE OF DEATH

124

69 0017387

318

1003

Registrar's No. 3734

DO NOT WRITE  
ON THIS STUBVS 300  
Rev. 1/68

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

DECEASED—NAME		FIRST	MIDDLE	LAST	SEX	DATE OF DEATH (MONTH, DAY, YEAR)	
1. Margaret Genevieve Eaton					2. Female	3. April 12, 1969	
RACE WHITE, NEGRO, AMERICAN INDIAN, ETC. (SPECIFY)		AGE—LAST BIRTHDAY (YEARS)	UNDER 1 YEAR	UNDER 1 DAY	DATE OF BIRTH (MONTH, DAY, YEAR)		COUNTY OF DEATH
4. White		5a. 71	5b. MOS. 5c. DAYS	5d. HOURS 5e. MIN.	6. Sept. 20, 1897		7a.
CITY, TOWN, OR LOCATION OF DEATH		INSIDE CITY LIMITS (SPECIFY YES OR NO)		HOSPITAL OR OTHER INSTITUTION—NAME (IF NOT IN EITHER, GIVE STREET AND NUMBER)			
7b. St. Louis		7c. yes		7d. Incarnate Word Hospital			
STATE OF BIRTH (IF NOT IN U.S.A., NAME AND COUNTRY)		CITIZEN OF WHAT COUNTRY		MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (SPECIFY)		SURVIVING SPOUSE (IF WIFE, GIVE MAIDEN NAME)	
8. Missouri		9. USA		10. Widowed		11.	
SOCIAL SECURITY NUMBER		USUAL OCCUPATION (GIVE KIND OF WORK DONE DURING MOST OF WORKING LIFE, EVEN IF RETIRED)		KIND OF BUSINESS OR INDUSTRY			
12. 491-26-4847A		13a. Housewife		13b. At Home			
RESIDENCE—STATE		COUNTY	CITY, TOWN, OR LOCATION		INSIDE CITY LIMITS (SPECIFY YES OR NO)		STREET AND NUMBER
14a. Missouri		14b. Iron	14c. Annapolis		14d. yes		14e.
FATHER—NAME		FIRST	MIDDLE	LAST	MOTHER—MAIDEN NAME		FIRST MIDDLE LAST
15. Thomas Perry					16. Anna Simpson		
INFORMANT—NAME				MAILING ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP)			
17a. E. J. Eaton				17b. Annapolis, Mo.			
PART I. DEATH WAS CAUSED BY:		[ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c)]					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
18. IMMEDIATE CAUSE							
(a) Myocarditis							
DUE TO, OR AS A CONSEQUENCE OF:							
(b) Generalized Atherosclerosis							
DUE TO, OR AS A CONSEQUENCE OF:							
(c) Diabetes mellitus							
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST							
PART II. OTHER SIGNIFICANT CONDITIONS. CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (a)		ACCUPTSY (YES OR NO)			IF YES WERE FINDINGS CONSIDERED IN DETERMINING CAUSE OF DEATH		
Acute mesenteric Thrombosis		19a. No			19b.		
ACCIDENT, SUICIDE, HOMICIDE, OR UNDETERMINED (SPECIFY)		DATE OF INJURY (MONTH, DAY, YEAR)	HOUR	HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART I OR PART II, ITEM 18)			
20a.		20b.	20c.	20d.			
INJURY AT WORK (SPECIFY YES OR NO)		PLACE OF INJURY AT HOME, FARM, STREET, FACTORY, OFFICE BLDG., ETC. (SPECIFY)		LOCATION (STREET OR R.F.D. NO., CITY OR TOWN, STATE)			
20e.		20f.		20g.			
CERTIFICATION—PHYSICIAN:		MONTH	DAY	YEAR	AND LAST SAW HIM/HER ALIVE ON	I DID NOT VIEW THE BODY AFTER DEATH.	DEATH OCCURRED AT THE PLACE, ON THE (HOUR) DATE, AND, TO THE BEST OF MY KNOWLEDGE, DUE TO THE CAUSE(S) STATED.
21a. ATTENDED FROM		11	17	1969	21c. 4 12 1969	21d.	21e. 2:20 P.
21b. DECEASED FROM		4	12	1969			
CERTIFICATION—MEDICAL EXAMINER OR CORONER: ON THE BASIS OF THE EXAMINATION OF THE BODY AND/OR THE INVESTIGATION, IN MY OPINION, DEATH OCCURRED ON THE DATE AND DUE TO THE CAUSE(S) STATED.		HOUR OF DEATH		THE DECEDENT WAS PRONOUNCED DEAD			
22a.		M., 22b.		YEAR HOUR			
CERTIFIER—NAME (TYPE OR PRINT)		SIGNATURE		DEGREE OR TITLE		DATE SIGNED (MONTH, DAY, YEAR)	
23a. Thomas F. Summers, M.D.		23b. Thomas F. Summers, M.D.		23c. 4-14-69		23d.	
MAILING ADDRESS—CERTIFIER		STREET OR R.F.D. NO.		CITY OR TOWN		STATE ZIP	
23a. 3624 South Broadway		St. Louis		Mo.		63118	
BURIAL, CREMATION, REMOVAL (SPECIFY)		CEMETERY OR CREMATORY—NAME		LOCATION			
24a. Removal		24b. Annapolis Cemetery		24c. Annapolis, Mo.			
DATE (MONTH, DAY, YEAR)		FUNERAL HOME—NAME AND ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP)					
24d. 4-14-69		25a. White Funeral Home, Ironton, Mo.					
FUNERAL DIRECTOR—SIGNATURE		REGISTRAR—SIGNATURE		DATE RECEIVED BY LOCAL REGISTRAR			
25b. Lawrence E. Meyer		25c. Smith, M.D.		26b. APR 15 1969			

USUAL RESIDENCE WHERE DECEASED LIVED. IF DEATH OCCURRED IN INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION.

DECEASED

PARENTS

CAUSE

CERTIFIER

BURIAL

Type or print in  
PERMANENT BLACK INK.  
See handbook for instructions.

9. 1

10a. 71

10b.

11. 0

12. 2

13. 250.9

14.

15. 4

16.

17.

18. 0

19. CREDITS

20.

63

04901

**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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed

*J. W. Dumbley*

Licensed Embalmer No.

*13653*

P. O. Address

*St. Louis Mo.*

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.