

TEXAS DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

STATE OF TEXAS

STATE FILE NO.

1. PLACE OF DEATH a. COUNTY Crosby b. CITY OR TOWN (If outside city limits, give precinct no.) Crosbyton c. LENGTH OF STAY in 1 day d. NAME OF (If not in hospital, give street address) HOSPITAL OR INSTITUTION e. IS PLACE OF DEATH INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Texas b. COUNTY Upton c. CITY OR TOWN (If outside city limits, give precinct no.) Rankin d. STREET ADDRESS (If rural, give location) e. IS RESIDENCE INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) (a) First Celestine (b) Middle D. (c) Last Eason		4. DATE OF DEATH Nov. 11, 1949					
5. SEX Female	6. COLOR OR RACE White	7. MARRIAGE STATUS Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Jan. 27, 1876	9. AGE (In years last birthday) 73 IF UNDER 1 YEAR: Months 9 Days 14 IF UNDER 24 HRS.: Hours 9 Minutes 14	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		
10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? 			
13. FATHER'S NAME T. B. Stout			14. MOTHER'S MAIDEN NAME Mary Jane Kelsey				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 		17. INFORMANT Mrs. J. W. Kennedy			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoms of head of Pancreas DUE TO (b) Gall Bladder infection DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						Interval between onset and death ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Metastasis to liver						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ Not while _____ Work <input type="checkbox"/> at Work <input type="checkbox"/>					
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office building, etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY _____ STATE _____			
21. I hereby certify that I attended the deceased from 11-10- , 19 49 to 11-11- , 19 49 and last saw the deceased alive on 11-11 , 19 49 Death occurred at 4:27 A m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE M. R. Snodgrass		22b. ADDRESS Crosbyton, Texas		22c. DATE SIGNED 11-14-49			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov. 12, 1949		23c. NAME OF CEMETERY OR CREMATORY Willow Cemetery			
23d. LOCATION (City, town, or county) Haskell (State) Texas		24. FUNERAL DIRECTOR'S SIGNATURE King Funeral Home A. R. King #2479					
25a. REGISTRAR'S FILE NO. 32		25b. DATE REC'D BY LOCAL REGISTRAR 11-15-49		25c. REGISTRAR'S SIGNATURE W. H. Nickson			
IF DECEASED SERVED IN U.S. ARMED FORCES, FILL OUT THE FOLLOWING: Is the deceased reported to have been in such service? _____ Name of organization in which service was rendered? _____ Serial number of discharge papers or adjusted service certificate? _____ Name of next of kin or of next friend? _____ Post Office Address? _____							
IF DECEASED WAS MARRIED, FILL OUT THE FOLLOWING: Name of husband or wife _____ Age in years _____							
IF DECEASED IS AN UNIDENTIFIED PERSON, FILL OUT THE FOLLOWING: Color of Hair? _____ Color of Eyes? _____ Height? _____ Weight? _____ Deformities? _____ Ft. _____ In. _____ Tattoo Marks? _____ Other marks of identification? _____							
STATE OF TEXAS, } COUNTY OF Crosby }							
I Hereby Certify that the above certificate is a true and accurate copy of the record of death of CELESTINE D. EASON , filed in my office, and is of record on							
Page 279 Vol. 4 of the Records of Deaths of the County of CROSBY , Texas.							
Witness my hand and seal of office this 27th day of MARCH , 19 72							
By Lloyd M. Gurnee COUNTY CLERK, CROSBY COUNTY, TEXAS							