

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

1440
400

State File No. _____
Registrar's No. _____

Registration District No. 299

Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 14 days
In this community Unknown
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(d) Street No. 1000 E. 14th St.
(e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME SETH EAGLE
(b) If veteran, name war _____ (c) Social Security No. No

4. Sex M. 5. Color or race W.
6. (a) Single, widowed, married, divorced Wid.
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan 10th 1858
(Month) (Day) (Year)

8. AGE: Years 83 Months _____ Days 7 If less than one day hr. _____ min.

9. Birthplace Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER { 12. Name John Eagle
13. Birthplace Ohio
14. Maiden name Emma Kimberly
15. Birthplace Ohio

16. (a) Informant Record clerk
(b) Address K.C. General Hospital, K.C. Mo.

17. (a) Burial (b) Date thereof 1-28-41
(c) Place: burial or cremation Buried

18. (a) Signature of funeral director [Signature]
(b) Address [Address]
19. (a) Jan 28 1941 (b) M. M. Brown
(Data received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan. day 17th
year 1941 hour 9 minute 45 A. M.

21. I hereby certify that I attended the deceased from 1-3-41 19. to 1-17-41 19. that I last saw h. im alive on 1-17-41 19. and that death occurred on the date and hour stated above.

Immediate cause of death CEREBRAL HEMORRHAGE
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature Tracy R. Brown (M. D. or other) _____
Address Med. Dir. K.C. Gen. Hospital, K.C. Mo.

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

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

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 *Wm A. Johnson*

Licensed Embalmer No. *3089*

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.