No. 2
-1-4-41
-17-39
X25390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

1941 STANDARD CERTIFICATE OF DEATH

State File No. 20615

FILLED JUL 7

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 2145

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City Mo (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2416 - E - 10 st (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community 13 yrs — years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City (If outside city or town limits, write "RURAL")

(d) Street No. 2416 - E - 10 st (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME James Tillman Eslinger

3. (b) If veteran, name war No —

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Sarah Eslinger

6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased Aug - 16 1873 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	67	9	16	hr. min.

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

10. Usual occupation Lumber man (Retired)

11. Industry or business Mo. Pac. R.R.Co.

FATHER
12. Name Eslinger
13. Birthplace No Record (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name No Record
15. Birthplace No Record (City, town, or county) (State or foreign country)

16. (a) Informant Sarah Eslinger

(b) Address 2416 - E - 10 st

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof June 3 - 1941 (Month) (Day) (Year)

(c) Place: burial or cremation Sedalia Mo.

18. (a) Signature of funeral director Mrs. C. R. Forster

(b) Address 918 Brooklyn K.C. Mo

19. (a) 6/3/41 (Date received local registrar) (b) N. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 2 year 1941 hour 12 minute 05 a.M.

21. I hereby certify that I attended the deceased from Jan 25, 1941, to June 2, 1941; that I last saw him alive on June 1, 1941, 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Parkinson's Disease	
Due to Unknown	15 yrs
Due to	
Other conditions X (Include pregnancy within 3 months of death)	
Major findings: Of operations X	
Of autopsy X	

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 Dr. Frank E. Day (M. D. or other) DO

Address 4316 E 9th K.C. Mo Date signed 6-2-41

(Licensed Embalmer's Statement on Reverse Side)

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. Gerald F. Wade

Licensed Embalmer No. 4172

P. O. Address K.C. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

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