

FILED MAR 27 1944

Registration District No. 150

Primary Registration District No. 5572

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

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Russell Springs, Miss.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Jackson County Home for Aged
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 yrs. 1 mo. 8 da.
In this community 15 yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 523 Grand ave.
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country -

3. (a) PRINT FULL NAME Ray George Eiler

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced, Separated
6. (b) Name of husband or wife: _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: Mar. 11 1885
(Month) (Day) (Year)

8. AGE: Years 58 Months 11 Days 17 If less than one day hr. _____ min. _____

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

10. Usual occupation Machinist

11. Industry or business Unknown

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant Reuben Jackson County Home
(b) Address Rt. 4, Independence, Mo.

17. (a) Anatomical (b) Date thereof 3-1-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation W.C. College of Dentistry

18. (a) Signature of funeral director W.C. Langeford
(b) Address 1110 1/2
19. (a) Mar. 1, 1943 (b) F.M. Schickel
(Date received local registrar) (Registrar's Signature)

MOTHER FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 28
year 1944 hour 2 minute 9 M.

21. I hereby certify that I attended the deceased from 1/20, 1942 to 2/28, 1944
that I last saw him alive on 2/28, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death: Mitral regurgitation
Duration _____

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? _____
(City or town) (County) (State)

(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 J.H. Greene (M. D. or other)
Address Independence Date signed 2/29/44

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 *W. B. Kingford*
Licensed Embalmer No. *3837*
P. O. Address *Les Perrier*

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.