S. No. 2
M—8-43
. 5-17-39
P I X37823

100270

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 21 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 1341

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5511

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
2425 Troost /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 2 Weeks
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 2425 Troost 8
(If rural, give location) 0

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

If yes, name country

3. (a) PRINT FULL NAME Ernest Eddings

3. (b) If veteran, name war No

3. (c) Social Security No. 328-03-0389

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife Ina Eddings

6. (c) Age of husband or wife if alive about 60 years

7. Birth date of deceased Sept 17 1886
(Month) (Day) (Year)

8. AGE: Years 59 ~~60~~ Months 3 Days 13 If less than one day ..... hr. ..... min.

9. Birthplace Stratford Mo 0
(City, town, or county) (State or foreign country)

10. Usual occupation Moulder

11. Industry or business Woods & Everett Stove Co

FATHER
12. Name Matthew Eddings
13. Birthplace Georgia /
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Anna Poynor
15. Birthplace Georgia /
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Maude Mashburn
(b) Address 2425 Troost

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/3/46 5
(Month) (Day) (Year)

(c) Place: burial or cremation Springfield Mo

18. (a) Signature of funeral director Quirk & Cobin Co
(b) Address 20 West Linwood

19. (a) 12-31-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 30th day Dec
year 1945 hour 3:05 minute A M.

21. I hereby certify that I attended the deceased from 12-16-45, 19..., to 12-30, 1945, that I last saw him alive on 12-29-45, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Bronchial Pneumonia

Due to Cerebral Hemorrhage 4 mo

Due to Decompensated Heart with arteriosclerosis

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 95 C

Of autopsy

Duration

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 M L Fletcher (M.D. or other) DO

Address 1103 E 47 KC Mo Date signed 1-9-46

(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 Charles M Surk

Licensed Embalmer No. 3774

P. O. Address Y. C. 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 this body is not embalmed, fact should be so stated above.