

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9035**
Registrar's No. **949**

Registration District No. **149** Primary Registration District No. **1002**

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

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:
316 No. Van Brunt
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community 1 1/4 years

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. 316 No. Van Brunt **8**
(If rural, give location)

(e) Citizen of foreign country? no **0** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME CHARLES BURTON EELLS

3. (b) If veteran, name war no 3. (c) Social Security No. 487-07-6117

4. Sex male **0** 5. Color or race white

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

6. (b) Name of husband or wife Ellen Frances 6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased March 19 1874
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 1 year 1947 hour 4 minute 50 A. M.

21. I hereby certify that I attended the deceased from May 27 1946, to July 1 1947
that I last saw him alive on July 26 1947
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>72</u>	<u>11</u>	<u>13</u>	hr. _____ min. _____

Immediate cause of death Cerebral thrombosis
Chronic myocarditis

Due to Metabolic Valvular Disease **3 years**

Due to _____

Other conditions Hypertension **3 years**
(Include pregnancy within 3 months of death)

Duration

9 months

2 years

3 years

3 years

PHYSICIAN

Underline the cause to which death should be charged statistically.

MOTHER FATHER

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

10. Usual occupation Accountant -retired

11. Industry or business Long Bell Lumber Co.

12. Name Thomas M Eells

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

14. Maiden name Sate Phenecie

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

16. (a) Informant Ellen F. Eells

(b) Address 316 No Van Brunt

17. (a) Burial (b) Date thereof 3-3-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah

18. (a) Signature of funeral director C.H. Blackman & Son, Inc.

(b) Address 2825 Independence Blvd.

19. (a) 3-3-47 (b) Shiraldine Holmes
(Date received local registrar) (Registrar's signature)

Major findings: Of operations _____

Of autopsy not made

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 C.W. Rose (M. D. or other) M.D.
Address 10391 Elmwood Date signed 3/1/47

103 N Elmway
C.W. Rose

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 Q. W. McFarland
Licensed Embalmer No. 4397
P. O. Address Kansas City, 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.