

FILED NOV 18 1947

Registration District No.

Primary Registration District No. 3013

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

1. PLACE OF DEATH

(a) County Clay

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

(c) Name of hospital or institution: None  
823 E 23 N.K.C. Mo.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None  
(Specify whether years, months or days)

In this community 2 year's

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clay 24

(c) City or town North Kansas City 3  
(If outside city or town limits, write "RURAL") 1

(d) Street No. 823 E 23 St.  
(If rural, give location)

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

If yes, name country None

3. (a) PRINT FULL NAME WILL H. EDDY

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex MALE

5. Color or race WAT

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

6. (b) Name of husband or wife INEZ EDDY

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

7. Birth date of deceased AUG. 5 1860  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>87</u>	<u>3</u>	<u>0</u>	<u>—</u> hr. <u>—</u> min.

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

10. Usual occupation Retired Machinist

11. Industry or business Same as Above

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Howard R. Eddy

(b) Address 823 E 23 N.K.C. Mo.

17. (a) Removal (b) Date thereof 11/16/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Springfield, Mo

18. (a) Signature of funeral director Morton Smith

(b) Address 822 Armour Rd

19. (a) Nov 6 - 1947 (b) Beulah Kitchen  
(Date received local registrar) (Registrar's signature) 63

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 5<sup>th</sup>  
year 1947 hour 9:50 minutes P. M.

21. I hereby certify that I attended the deceased from October 20  
1947, to November 5, 1947;  
that I last saw him alive on November 5, 1947;  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Myocardial Infarct

Due to Myocardial Degeneration

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:  
Of operations None

Of autopsy None

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 0

23. Signature Carl R. Frost (M. D. or other)  
Address 719 W. 169th St. C. Mo. Date signed 11/16/47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

11-17-47

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.....

*Charles J. Shively*

Registered Apprentice No. 449

working under my personal supervision.

Signed *Theron O. Smith*

Licensed Embalmer No. 3928

P. O. Address *W.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.