

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

23678

State File No. _____

FILED AUG 4 1952

REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 789

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

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY OR TOWN <u>St Joseph</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u> <u>3738</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital no 2</u>		d. STREET ADDRESS (If rural, give location) <u>5000 Walnut Street</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Earl</u> b. (Middle) <u>E</u> c. (Last) <u>Eshelman</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July 25 52</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u>	8. PLACE OF BIRTH <u>1085 OF BIRTH 1885 4-25</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>67</u> <input type="checkbox"/> UNDER 1 YEAR <u>3</u> <input type="checkbox"/> UNDER 11 HRS. Days Hours Min.
13a. FATHER'S NAME <u>not given</u>		13b. MOTHER'S MAIDEN NAME <u>not given</u>	11. BIRTHPLACE (State or foreign country) <u>Beatrice Neb</u> <u>1</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		14. NAME OF HUSBAND OR WIFE	
19a. DATE OF OPERATION		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Eleanor Howell 5000 Walnut S.K.B. Mo</u>	
19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 1</u> , 19 <u>52</u> , to <u>July 25</u> , 19 <u>52</u> ; that I last saw the deceased alive on <u>July 24</u> , 19 <u>52</u> ; and that death occurred at <u>4:30</u> a.m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>Forrest Thomas M.D.</u>		23b. ADDRESS <u>St Joseph Mo 7, State Hospital</u>	23c. DATE SIGNED <u>7/25 52</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>7-28-52</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Washington</u>	24d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>
DATE RECD BY LOCAL REG. <u>July 28, 1952</u>	REGISTRAR'S SIGNATURE <u>Carl C. Cash</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Norman W. Sidenfaders</u>	

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 _____

..... Student Embalmer No. _____
working under my personal supervision.

Signed
Student Embalmer

Signed Robert H. Heph
.....

Licensed Embalmer No. 3308
.....

P. O. Address St. Joseph, 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.