

Health,  
& Welfare  
Public  
Service

FILED NOV 5 1957

STANDARD CERTIFICATE OF DEATH

35780  
STATE FILE NUMBER  
4793

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

5. 300  
1-57

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>KANSAS CITY</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>210 EAST ARMAOUR ELMS NURSING HOME</b>		Length of stay in lb <b>70 YEARS</b>	d. STREET ADDRESS (If outside, give location) <b>223 EAST 33<sup>RD</sup> STREET</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>EDWARD CHARLES EADES</b>			4. DATE OF DEATH Month Day Year <b>OCT. 16-1957</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 19-1867</b>	9. AGE (In years last birthday) <b>90</b> IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED CONTRACTOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PRINTING</b>	11. BIRTHPLACE (City and state or country) <b>MAGNOLIA, ILLINOIS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>HEZEKIAH EADES</b>		13b. MOTHER'S MAIDEN NAME <b>MARY BOWER</b>		14. NAME OF HUSBAND OR WIFE <b>unknown</b>	

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>494-46-4359</b>	17. INFORMANT <b>EDWARD J. EADES, JR.</b> Address <b>223 EAST 33<sup>RD</sup> ST. KANSAS CITY, MO.</b>
---	---	---

18. CAUSE OF DEATH (Enter only one cause per part for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho - Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		<b>491X</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____		

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
---	--	---

21. I attended the deceased from **10-1-57** to **10-15-57** and last saw her/him alive on **10-15-57**  
Death occurred at **11:15 A.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Ralph Casford M.D.</b>	22b. ADDRESS <b>221 Pl. Med. Bldg.</b>	22c. DATE SIGNED
---	---	------------------

23a. BURIAL, CREMATION, REMOVAL (City) <b>BURIAL</b>	23b. DATE <b>OCT. 18-1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FOREST HILL CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MISSOURI</b>
---	----------------------------------	---	--

24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS</b> ADDRESS <b>1331 BRUSH CREEK KANSAS CITY, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>10-17-57</b>	26. REGISTRAR'S SIGNATURE <b>Reva Minshall</b>
--	---	---

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

M.D. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
Ralph Casford

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.

Student .....  
Signature of Student Embalmer

Signed *Basil P. Honey* .....

Licensed Embalmer No. *2724* .....

P. O. Address *2724* .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.