

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-021871
STATE FILE NUMBER

FILED JUL 11 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2948

300
-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	588 CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Grosse N. Home		Length of stay in 1b 76 yrs	d. STREET ADDRESS (If outside, give location) 4201 Linwood Blvd Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last AUGUST F. EYSELL			4. DATE OF DEATH Month Day Year 6 9 58
5. SEX Ma	6. COLOR OR RACE Wh	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-20-1866
9. AGE (In years birthday) 91		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most working life or, if retired) Ret. Druggist		10b. KIND OF BUSINESS OR INDUSTRY Drug	11. BIRTHPLACE (City and state or country) 4 Rinteln, Germany
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Otto Eysell	
13b. MOTHER'S MAIDEN NAME Marie Boedecker		14. NAME OF HUSBAND OR WIFE Eleanor G. Eysell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No xx		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Mrs. Eleanor G. Eysell, 4201 Linwood
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage with right hemioplegia			INTERVAL BETWEEN ONSET AND DEATH 8 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Senility			
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 12-18-57 , to 6-9-58 and last saw her/him alive on 6-9-58 Death occurred at 6:00 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Ralph Perry M.D.		22b. ADDRESS 4800 East 24th, Kansas City, Mo	
		22c. DATE SIGNED June 10, 1958	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 6-11-58	
23c. NAME OF CEMETERY OR CREMATORY Elmwood		23d. LOCATION (City, town, or county) (State) Kansas City Mo.	
24. FUNERAL DIRECTOR ADDRESS Wagner Funeral Home, K C Mo		25. DATE RECD. BY LOCAL REG. 6-11-58	
		26. REGISTRAR'S SIGNATURE Neve Marshall	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
Ralph Perry

All diseases in Part I must be causally related.

12:30 - 4:30

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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 *Alvin R. Haunschild*

Licensed Embalmer No. *4159*
P. O. Address *K. C. M.*

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.