

Health, Welfare & Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-005524
STATE FILE NUMBER
511

FILED FEB 17 1959

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

300
-57

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	a. CITY OR TOWN <u>Kansas City</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>General Hospital</u>		Length of stay in 1b <u>72 YEARS</u>	d. STREET ADDRESS (If outside, give location) <u>3216 Wallace</u>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>ELMER</u> Last <u>EDDY</u>			4. DATE OF DEATH Month <u>1</u> Day <u>25</u> Year <u>1959</u>			
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 6 1886</u>	9. AGE (In years last birthday) <u>72</u>	10. FUNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONTRACTOR</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>FOR SELF</u>	11. BIRTHPLACE (City and state or country) <u>KANSAS CITY MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>CASHA K. EDDY</u>	13b. MOTHER'S MAIDEN NAME <u>ALLETTA A. UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>MRS. ANNA M. EDDY</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>491-20-8371A</u>	17. INFORMANT <u>MRS. ANNA M. EDDY</u> Address <u>3216 WALLACE KANSAS CITY MISSOURI</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>undetermined (pending autopsy)</u> Broncho pneumonia Interval between ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____ DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>If Surgery Gastric ulcer</u>	

19. WAS AUTOPSY PERFORMED? 1 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____ Month, Day, Year _____

20d. INJURY OCCURRED WHILE AT WORK <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
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21. I attended the deceased from <u>1-15-59</u> to <u>1-25-59</u> and last saw ^{her} alive on <u>1-25-59</u> Death occurred at <u>5:08 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>Abraham Galperin</u> (Degree or title)	22b. ADDRESS <u>San Hope P.C. Mo.</u>	22c. DATE SIGNED <u>1-26-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>JAN 27 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. MORIAN CEMETERY</u>	23d. LOCATION (City, town, or country) (State) <u>KANSAS CITY MISSOURI</u>
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24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S SONS</u> ADDRESS <u>1331-BRUSH CREEK KANSAS CITY, MO.</u>	25. DATE RECD. BY LOCAL REG. <u>1-27-59</u>	26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>
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(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

Abraham Galperin M.D. City Black Ink or Ribbon Type Write if Possible

MEDICAL CERTIFICATION

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 *Chester K. Brown*

Licensed Embalmer No. *4931*
P. O. Address *KE 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.