URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

[redacted]

MENDED

FILED VS JAN 25 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6305 STATE FILE NUMBER 59-046744

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City
Length of stay in 1b: 3 weeks
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Research Hospital — Inside Limits Yes ☐# No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Clay
c. CITY OR TOWN North Kansas City — Inside Limits Yes ☐# No ☐
d. STREET ADDRESS (If outside, give location) 2200 Ozark — Reside on Farm Yes ☐ No ☐#

3. NAME OF DECEASED (Type or print) First: Hazel Middle: Last: Eggeman
4. DATE OF DEATH Month: Dec. Day: 31, Year: 1959

5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐# Widowed ☐ Divorced ☐
8. DATE OF BIRTH: June
9. AGE (last birthday): 45
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HR: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Lawrence County Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: William F. Eggeman
13b. MOTHER'S MAIDEN NAME: Anna Jackson
14. NAME OF HUSBAND OR WIFE: —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Culver Underwood Address: Butler Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Uraemia	7 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Kimmel-Stiele-Wilson Syndrome	2 years
DUE TO (c)	Diabetes Mellitus	10 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (b): Arterial Hypertension. Secondary Anemia

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. Month, Day, Year

20d. ~~INJURY OCCURRED~~ WHILE AT WORK ☐ NOT WHILE 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 1950, to Dec 31, 1959 and last saw her/him alive on Dec 31, 1959
Death occurred at 11:20 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Carl R. Ferris (Degree or title) M.D.
22b. ADDRESS 535 Argyle Bldg Kansas City, Missouri
22c. DATE SIGNED 1-1-60

BY AFFIDAVIT OF Carl R. Ferris

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 1/1/60
23c. NAME OF CEMETERY OR CREMATORY: Salem
23d. LOCATION (City, town, or county) (State): Lawrence County Mo.

24. FUNERAL DIRECTOR: Stine & McClure ADDRESS: K.C. Mo.
25. DATE RECD. BY LOCAL REG.: 1-1-60
26. REGISTRAR'S SIGNATURE: Neva Marshall

(Licensed Embalmer's Statement on Reverse Side)

JUN 7 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. 4233

P. O. Address K. C. M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com 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.