

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Registration District No. 299 Primary Registration District No. 1002

REC'D NOV 14 1939

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
552I Jackson
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community 30 Yrs.
 years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Kansas City
 (If outside city or town limits, write "RURAL")
 (d) Street No. 552I Jackson
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Eber C. Topping 152
 3. (b) If veteran, name war No
 3. (c) Social Security No. 10

4. Sex Male 5. Color or race Wh. 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ellen Topping 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept. 18th, 1891
 (Month) (Day) (Year)

8. AGE: Years 48 Months 0 Days 24 If less than one day _____ hr. _____ min.

9. Birthplace Kansas
 (City, town, or county) (State or foreign country)

10. Usual occupation U.C. Star Carrier

11. Industry or business _____

12. Name E.C. Topping

13. Birthplace Ohio
 (City, town, or county) (State or foreign country)

14. Maiden name Sarah Terton

15. Birthplace Wis.
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature _____
 (b) Address 552I Jackson

17. (a) Burial (b) Date thereof 10/16/39
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Marys Cemetery

18. (a) Signature of funeral director F. Lavberry
 (b) Address 2315 Linwood Blvd.

19. (a) 10-13-39 (b) [Signature]
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Oct day 13
 year 1939 hour 2 minute 30 P.M.

21. I hereby certify that I attended the deceased from Oct 3, 1939, to Oct 13, 1939
 that I last saw him alive on Oct 12, 1939
 and that death occurred on the date and hour stated above.

Immediate cause of death Essentialy unknown

Due to 94B

Other conditions Hypertension
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations none
 Of autopsy _____

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury ✓

23. Signature Glenn H. Boyler (M. D. examiner) 1
 Address 1072 Purif. Bldg Date signed 10-13-39

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically

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 _____,
_____, Registered Apprentice No. _____,
working under my personal supervision.

Signed _____

Ray E. Sward

Licensed Embalmer No. 2560

P. O. Address 2315 Linwood Blvd.

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, above space should be left blank.