

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **37673**

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **4271**

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

1. PLACE OF DEATH:

(a) County **Jackson**

(b) City or town **ansas City Missouri**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
**2465 Quincy**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **25 years**  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Elizabeth Eck**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **No**

4. Sex **Fe**

5. Color or race **W**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Charles Clayton Eck**

6. (c) Age of husband or wife if alive **64** years

7. Birth date of deceased **January 1 1876**  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<b>64</b>	<b>10</b>	<b>7</b>	hr. min.

9. Birthplace **N. Y.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **House Wife**

11. Industry or business

MOTHER FATHER {

12. Name **Unknown**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Charles Clayton Eck**

(b) Address **2465 Quincy**

17. (a) **Burial** (b) Date thereof **Nov- 11 1940**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Forest Hill**

18. (a) Signature of funeral director **Mrs. C. L. Forster**

(b) Address **918 Brooklyn**

19. (a) **Nov. 9, 1940** (b) **M. M. Browne**  
(Date received local registrar) (Registrar's signature)

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. **2465 Quincy**  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov-** day **8<sup>th</sup>** year **1940** hour **10** minute **10** A.M.

21. I hereby certify that I attended the deceased from **Aug 29-** **1940** to **Nov- 8<sup>th</sup> 1940**

that I last saw her alive on **Nov 7<sup>th</sup> 1940** and that death occurred on the date and hour stated above.

Immediate cause of death **Uremia**

Due to **Cancer - Breast**

Due to **50**

Other conditions (Include pregnancy within 3 months of death)  
**David H. Reed, D.O.**

Major findings: **Of operations**

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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 **3**

23. Signature **David H. Reed, D.O.** (a) or other \_\_\_\_\_  
Address **2 W. 31st St. R.C. Mo.** Date signed **11-8-40**

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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: me

....., Registered Apprentice No.....

.....  
working under my personal supervision.

Signed Herzil P. Browning

Licensed Embalmer No. 2724

P. O. Address H. C. 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 this body is not embalmed, fact should be so stated above.**