

Registration District No. **3779**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**

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

(c) Name of hospital or institution:
2634 Paseo
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community **58 years**
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. **2634 Paseo**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Mr. Charles W. Eoff**

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

3. (c) Social Security No. **None**

4. Sex **Male**

5. Color or race **White**

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

6. (b) Name of husband or wife **Henrietta H. Eoff**

6. (c) Age of husband or wife if alive **83** years

7. Birth date of deceased **February 4 1854**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	88	2	24	hr. _____ min. _____

9. Birthplace **Wheeling W. Va.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business _____

12. Name **Beverly M. Eoff**

13. Birthplace **Wheeling W. Va.**
(City, town, or county) (State or foreign country)

14. Maiden name **Harriet Woods**

15. Birthplace **Wheeling W. Va.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Henrietta H. Eoff**

(b) Address **2634 Paseo**

17. (a) **Burial** (b) Date thereof **4-30-42**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Moriah Cemetery**

18. (a) Signature of funeral director **Freeman Mortuary**

(b) Address **Kansas City, Mo.**

19. (a) **4-28-42** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **28**
year **1942** hour **5** minute **30 a.** M.

21. I hereby certify that I attended the deceased from **April 12**, 19**42**, to **April 28**, 19**42**, that I last saw him alive on **April 25**, 19**42**, and that death occurred on the date and hour stated above.

Immediate cause of death **Senility**

Due to **Had had gastric ulcer for several years**

Other conditions **117a**
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

Duration _____

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) _____ (r) Means of injury _____

23. Signature **D. M. Coleman** (M. D. or other) _____
Address **3801 Brooklyn** Date signed **4-28-42**

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

MOTHER FATHER

361

Mr. J. P. McClellan
3882
W. 6443
1-4

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 *J. P. McClellan*

Licensed Embalmer No. 2939

P. O. Address. F. O. 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.