

FILED FEB 3 1944  
Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

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: **4737 Wyoming 1**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **12 yrs** (Specify whether years, months or days)  
In this community **12 yrs**

3. (a) PRINT FULL NAME **William Francis Eoff**

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

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Widowed 2**

6. (b) Name of husband or wife **Unknown** 6. (c) Age of husband or wife if alive **—** years

7. Birth date of deceased **Oct 26 1863**  
(Month) (Day) (Year)

8. AGE: Years **80** Months **2** Days **16** If less than one day hr. min.

9. Birthplace **Boone Co Arkansas**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Farmer**

11. Industry or business

12. Name **A. Eoff**

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

14. Maiden name **Eivira Penil**

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

16. (a) Informant **E. M. Roberts**  
(b) Address **4737 Wyoming**

17. (a) **Burial** (b) Date thereof **1/14/44**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Maple Hill Cem**

18. (a) Signature of funeral director **[Signature]**

(b) Address

19. (a) **Jan 13, 1944** (b) **[Signature]**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Ja.**  
(c) City or town **Kansas City**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **4737 Wyoming**  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No) **No**  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **I** day **12**  
year **44** hour **3** minute **45 P.** M.

21. I hereby certify that I attended the deceased from **1/10/44** to **1/12/44** and that death occurred on the date and hour stated above.

that I last saw him alive on **1/12/44** and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial Infarction**

Due to **Fractured H. Femur**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations  Of autopsy

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) **Accident 18 ft**  
(b) Date of occurrence **Jan 5, 1944**  
(c) Where did injury occur? **Nevada Mo**  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial shop, in public place?  
**Public Place**  
(Specify type of place)

While at work?  (e) Means of injury **Fall**

23. Signature **[Signature]** (M. D. or other) **[Signature]**  
Address **221 1/2 P. Med Bldg** Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**