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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2344
Registrar's No. _____

FILED JUN 22 1944
Registration District No. _____

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:
K. C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 15 days (Specify whether 0)
In this community 2 weeks years, months or days
Hoffecker

3. (a) PRINT FULL NAME Wilfred Eaton Sr.

3. (b) If veteran, name war no 3. (c) Social Security No. 487-03-8532

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

6. (b) Name of husband or wife Irene Susan 6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased June 9, 1890
(Month) (Day) (Year)

8. AGE: Years 53 Months 7 Days 11 If less than one day hr. 21 min. 0

9. Birthplace St. Joseph Mo
(City, town, or county) (State or foreign country)

10. Usual occupation office mgr.

11. Industry or business Red Week Refining Co.

12. Name Lucian A. Eaton

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

14. Maiden name Ariel Hoffecker

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

16. (a) Informant Irene Susan Eaton

(b) Address 4319 Tracy

17. (a) Burial (b) Date thereof 6-1-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill

18. (a) Signature of funeral director Newcomer's Sons

(b) Address K. C. Mo

19. (a) 6-1-44 (b) N. E. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL") 9
(d) Street No. 4319 Tracy
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____ 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 30 year 1944 hour 3 minute A. M.

21. I hereby certify that I attended the deceased from May 15, 1944, to May 30, 1944
that I last saw him alive on May 30, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Ca. of Pancreas

Due to _____

Due to 469

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

Major findings: _____
Of operations _____

Of autopsy See above

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 0

23. Signature A. E. Upsher (M. D. or other) M. D.
Address Med. Dir. Gen'l Hosp. Date signed 5-31-44

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

MOTHER, FATHER

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

Emile M Calhoun

Licensed Embalmer No. *3506*

P. O. Address. *A & M O*

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.