

FILED JUL 12 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18900**
2644

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>mo</u> b. COUNTY <u>Jackson</u>			
b. CITY OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (In this place) <u>3 mo</u>		c. CITY OR TOWN <u>Kansas City</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Linnmont Nursing Home</u>				e. STREET ADDRESS (If rural, give location) <u>5542 Tracy 2418</u>			
3. NAME OF DECEASED (Type or Print) <u>Charles M Eubank</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>6 11 54</u>				
5. SEX <u>M</u>		6. COLOR OF RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>8-25-89</u>	
9. AGE (In years last birthday) <u>65</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Richard Eubank</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Laird</u>		14. NAME OF HUSBAND OR WIFE <u>Lorena</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Lorena Eubank</u> ADDRESS <u>5542 Tracy mo</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerosis</u> ANTECEDENT CAUSES <u>Arteriosclerosis</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>4500</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u> <u>3 yrs</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>1-6-54</u> 19 <u>54</u> , to <u>6-11-54</u> 19 <u>54</u> , that I last saw the deceased alive on <u>6-11-54</u> , 19 <u>54</u> , and that death occurred at <u>9:20 A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Frank Paul Lauren</u> (Degree or title) <u>State</u>				23b. ADDRESS <u>428 South white</u>		23c. DATE SIGNED <u>6-11-54</u>	
24a. BURIAL CREMATATION (REMOVAL) (Specify) <u>burial</u>		24b. DATE <u>June 14-1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem</u>		24d. LOCATION (City, town, or county) (State) <u>Sedalia mo mo</u>	
DATE REC'D BY LOCAL REG. <u>6-12-54</u>		REGISTRAR'S SIGNATURE <u>Geraldine Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Webb Funeral Home</u> ADDRESS <u>Blue Springs mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *P. B. Webb* 283

Licensed Embalmer No... *283*

P. O. Address *Blaine Sp.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.