

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27226**
3778

BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Bates	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KE-MO KANSAS CITY		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rich Hill Mo.	
c. LENGTH OF STAY (In this place) 3 das		d. STREET ADDRESS (If rural, give location) 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION Lakeside Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Ross	b. (Middle) Delbert	c. (Last) Eby	4. DATE OF DEATH (Month) (Day) (Year) Aug. 1. 1954
5. SEX M	6. COLOR OR RACE Wh	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 6. 1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Retired farmer	9. AGE (In years last birthday) 69 Months 5 Days 26
11. BIRTHPLACE (State or foreign country) Warrensburg Mo.		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME Samuel Eby	13b. MOTHER'S MAIDEN NAME Mary Jane Pearson	14. NAME OF HUSBAND OR WIFE Nellie Marion Eby
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. —	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Harley Reed of Sibley Mo.

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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Circulatory collapse.		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) myocardial degeneration DUE TO (c) Stragulated Inguinal		
II. OTHER SIGNIFICANT CONDITIONS- Conditions contributing to the death but not related to the disease or condition causing death. Hernia & Surgery		56/0	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO

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 **7:31** 19 **54**, to **8:11** 19 **54**, that I last saw the deceased alive on **8/1** 19 **54**, and that death occurred at **10P** m., from the causes and on the date stated above.

23a. SIGNATURE J. W. Higgins	(Degree or title) DO	23b. ADDRESS Buckner, Missouri	23c. DATE SIGNED Aug 2 .19
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24a. BURIAL, CREMATION, OR REMOVAL (Specify) Removal	24b. DATE Aug 4 1954	24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	24d. LOCATION (City, town, or county) (State) Greenwood Mo
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DATE REC'D BY LOCAL REG. 8-3-54	REGISTRAR'S SIGNATURE Geraldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE V. M. Reed	ADDRESS Buckner Mo
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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
Student Embalmer

Signed John R. Bidman

Licensed Embalmer No. 4531

P. O. Address Kansas City, 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.