

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-021338

STATE FILE NUMBER

FILED JUN 17 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2577

300  
1-57

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY Jackson  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Mo. b. COUNTY Jackson                                    |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN Kansas City  |  | c. CITY OR TOWN Kansas City  |   |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |  | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |   |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 1108 E. 108 th.St.  |  | d. STREET ADDRESS (If outside, give location) 1108 E. 108 th.St.   |   |
| Length of stay in lb 8 yrs.   |  | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED First Middle Last Benjamin Franklin Eye   |  |  | 4. DATE OF DEATH Month Day Year May 24, 1959                    |
| 5. SEX Male <input checked="" type="checkbox"/>   | 6. COLOR OR RACE White <input checked="" type="checkbox"/> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 20, 1863                                  |
| 9. AGE (In years or birthday) 96  |  | IF UNDER 1 YEAR Months Days  | IF UNDER 24 HRS. Hours Min.                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Retired  |  | 10b. KIND OF BUSINESS OR INDUSTRY  | 11. BIRTHPLACE (City and state or country) Illinois             |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A.   |  | 13a. FATHER'S NAME Benjamin Eye  |   |
| 13b. MOTHER'S MAIDEN NAME Unknown   |  | 14. NAME OF HUSBAND OR WIFE Louise Jane Miller   |   |
| 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. none   | 17. INFORMANT Mr. Boyd F. Eye                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Heart Block<br>Arterio-sclerosis<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) senility |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>INTERVAL BETWEEN ONSET AND DEATH hours years 4330        |   |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)   |   |
| 20c. TIME OF INJURY Hour .Month, Day, Year a.m. p.m.  |  | 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 20f. CITY, TOWN, OR LOCATION COUNTY STATE  |   |
| 21. I attended the deceased from May 19, 1959 to May 24, '59 and last saw him alive on May 22, 1959<br>Death occurred at 10:05 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.  |  |  |   |
| 22a. SIGNATURE Ada B. Rader M.D. (Degree or title)  |  | 22b. ADDRESS 13414 Locust Martin City, Mo  |   |
| 22c. DATE SIGNED 5-24-59  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal   | 23b. DATE 5/24/59  | 23c. NAME OF CEMETERY OR CREMATORY -   | 23d. LOCATION (City, town, or county) (State) Wellsville Kansas |
| 24. FUNERAL DIRECTOR Stine & McClure ADDRESS K.C.Mo.  |  | 25. DATE RECD. BY LOCAL REG. 5-24-59   | 26. REGISTRAR'S SIGNATURE Neva Marshall                         |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Ada B. Rader

W.A.L. - 5712  
13414 Joann of

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 Elmer D Triplett .....

Licensed Embalmer No. 4 P. 17 .....

P. O. Address San Antonio, Tex .....

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.