MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH
County Jackson — Registration District No. 395 — File No. 27160
Township — Primary Registration District No. — Registered No.
City Lone Jack (No. ..... St. ..... Ward)

2. FULL NAME Cornelius Edwards
(a) Residence. No. ..... St., ... Ward. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

SEP 25 1928

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

percussion auscultation

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Charlotte Edwards

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Aug 17-1841

7. AGE: 86 YEARS — MONTHS: 11 — DAYS: 18 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Minister of Gospel
(b) General nature of industry, business, or establishment in which employed (or employer): Regorused Latter
(c) Name of employer: Day Santo.

9. BIRTHPLACE (CITY OR TOWN): Evensville
(STATE OR COUNTRY): Indiana

PARENTS
10. NAME OF FATHER: Jesse Edwards
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Dont Know
(STATE OR COUNTRY): Dont Know
12. MAIDEN NAME OF MOTHER: Anderson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Dont Know
(STATE OR COUNTRY): Dont Know

14. INFORMANT: Earnest Edwards
(Address): Indep. Mo.

15. FILED Aug 5 1928 F. H. Tuttle M.D. REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Aug. 5 1928

17. I HEREBY CERTIFY, That I attended deceased from June 8, 1928, to Aug 8, 1928, that I last saw him alive on Aug 8, 1928, and that death occurred, on the date stated above, at 10-30 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Terminal Pneumonia Lobar
Following Fractured Hip
(duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (SECONDARY)
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS? Percussion auscultation

(Signed) J. C. Hader D.O., M.D.
, 19 (Address) Grain Valley, Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Mound Grove Cemetery — DATE OF BURIAL: 8/8 1928

20. UNDERTAKER: C. D. Carson & Son — ADDRESS: Indp. Mo.

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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
County Jackson — Registration District No. 395 — File No.
Township — Primary Registration District No. — Registered No.
City Lone Jack (No. ..., ... St. ..... Ward).

2. FULL NAME Cornelius Edwards
(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE — YEARS — MONTHS — DAYS — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED F. W. Tuttle MD 19 Blue Springs MD REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 5 1928

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19..., that I last saw h..... alive on ..... 19..., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Terminal pneumonia lobar following fractured hip from accidental fall (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. ..... mos. ..... ds.

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18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? ..... DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) ....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

N. B. ... THIS IS A PERMANENT RECOR...
CAUSE OF ... GE should be stated EXACTLY. PHYSICIA... ...ld st... ...y ...sified. Exact statement of OCCUPATION is ... important.
REGISTRARS ... RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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