

NOV 24 1939

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

35946
Do not use this space.

1. PLACE OF DEATH

(a) County Wallas 2 Registration District No. 240'
(b) Township Lincoln 1 Primary Registration District No. 5'339 Registered No. 9
(c) City Arkansas or (d) Street No. _____ St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov-7-1878

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
60 11 11

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. Housekeeper
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) Hamden Co (STATE OR COUNTRY) Mo

13. NAME Bill Edmunds

14. BIRTHPLACE (CITY OR TOWN) Cole Co (STATE OR COUNTRY) Mo

15. MAIDEN NAME May J. Cook

16. BIRTHPLACE (CITY OR TOWN) Arkansas (STATE OR COUNTRY)

17. INFORMANT Walter Scott (ADDRESS) Arkansas Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE M. Coen DATE Oct-19-39

19. FUNERAL DIRECTOR (NAME) L. B. Jones (ADDRESS) Buffalo Mo

20. FILED Nov 7, 1939 E. C. Williams Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct-18-1939

I HEREBY CERTIFY, That I attended deceased from Feb 2 1938 to Oct 18 1939

I last saw her alive on Oct 16 1939. Death is said

to have occurred on the date stated above, at 2 a.m.

The principal cause of death and related causes of importance were as follows:

Phonix myocarditis

Date of onset 1/8/39

Other contributory causes of importance:

Arteriosclerosis Liver 6 yr

Name of operation _____ Date of _____

What test confirmed diagnosis? PPA Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) R. A. Blosser, M. D.

(Address) Urbana, Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

RECEIVED
District Health Officer No. 7;
District File Number 7-39-1613
Date Filed 11-14-39

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.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.