

Registration District No. **318** Primary Registration District No. **2001**

1. PLACE OF DEATH:

- (a) County Greene
 (b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution Springfield Baptist Hosp. 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Charles Jay Edmonson

3. (b) If veteran, name war NO 3. (c) Social Security No.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lezzie Bloom Edmonson 6. (c) Age of husband or wife if _____ years

7. Birth date of deceased July - 10 1870
(Month) (Day) (Year)

8. AGE: Years 69 Months 3 Days 11 If less than one day _____ hr. _____ min.

9. Birthplace Polk County, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business _____

12. Name S. A. Edmonson

13. Birthplace Gen
(City, town, or county) (State or foreign country)

14. Maiden name Louisa Loney
 15. Birthplace Polk Co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Lezzie Edmonson

(b) Address Wesley Farm Mo

17. (a) Buried (b) Date thereof Oct 22 39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lucky Creek Cem

18. (a) Signature of funeral director Chas. A. George

(b) Address Wesley Farm Mo

19. (a) 10-22-1939 (b) Chas. A. George
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Greene
 (c) City or town Wesley Farm Rural
(If outside city or town limits, write "RURAL")
 (d) Street No. R 7 D # 3
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 20
 year 1939 hour 8 minute 15 M.

21. I hereby certify that I attended the deceased from Sept 1
 1939, to Oct 30, 1939;

that I last saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Intra cranial hemorrhage - acc or thrombosis
 Duration 16

Due to _____

Due to _____

Other conditions Hypertension
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) NO
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place)
 (c) Means of injury _____

23. Signature Ray Stallaway M. D. or other _____
 Address Springfield Mo Date signed _____

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. WHILE LEAVING—USE 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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *Warren D. Noble*

Licensed Embalmer No. *4005*

P. O. Address. *Springfield 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, above space should be left blank.

X