

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

40205
Do not use this space.

1. PLACE OF DEATH

(a) County Madison Registration District No. 638
 (b) Township St. Michael Primary Registration District No. 3028 Registered No. _____
 (c) City Fredericktown (d) Street No. _____
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

355 Donald Clovis Edmunds 9R
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 13 - 1939

7. AGE YEARS MONTHS did not live If LESS than 1 day, 7 1/2 hrs. or 7 1/2 min.

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.
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Fredericktown, Mo

FATHER 13. NAME Clovis Edmunds

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

MOTHER 15. MAIDEN NAME Lillian Albright

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Madison Co Mo

17. INFORMANT (ADDRESS) Clovis Edmunds

18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Grove Cem DATE Nov 17 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Rosen

20. FILED Dec 2 1939 S. C. Bloughter Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 13 1939

22. I HEREBY CERTIFY, That I attended deceased from birth 9:30 AM 1939 to 5:00 PM 1939. I last saw him alive on 9:30 AM 1939. Death is said to have occurred on the date stated above, at 5:00 p.m.

The principal cause of death and related causes of importance were as follows:
8. No Respiration
was a Blue Baby

Other contributory causes of importance: 159C

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy?

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? No
 If so, specify _____
 (Signed) M. B. Parker M.D.
 (Address) Fredericktown Mo

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.

STATE OF TEXAS
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

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.