

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.

FILED FEB 19 1940
489

Registration District No. _____

Primary Registration District No. 5558

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson, Missouri
(b) City or town Grandview, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Wyckoff Clinic
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 days
(Specify whether
In this community 15 yrs
years, months or days)

3. (a) PRINT FULL NAME Dorothy Edwards

8. (b) If veteran, name war No 8. (c) Social Security No. None

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

6. (b) Name of husband or wife Harold Edwards 6. (c) Age of husband or wife if alive 32 1/2 years

7. Birth date of deceased April 3 1913
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>26</u>	<u>9</u>	<u>6</u>	hr. min.

9. Birthplace Superior, Wisc.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Fred L. Wilmot

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

14. Maiden name Olive E. Kitti

15. Birthplace Calumet, Michigan
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Harold Edwards

(b) Address 2319 Norton

17. (a) Burial (b) Date thereof Jan. 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Mrs. C. L. Forster

(b) Address 918 Brooklyn Avenue, K.C. Mo.

19. (a) 2-8-40 (b) R. Lindsey & Sons
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City, Grandview, Mo. Missouri.
(If outside city or town limits, write "RURAL")
(d) Street No. 2319 Norton Avenue, K.C. Mo.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 9
year 1940 hour 6 minute 35 P. M.

21. I hereby certify that I attended the deceased from 11-24, 1939, to 1-9, 1940
that I last saw her alive on 1-9-40, and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Failure Duration 30 m.

Due to Toxemia from multiple pelvic abscess and peritonitis

Due to Self induced abortion performed in October 1939

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

Major findings: Multiple abscess & cavity filled with free pus
Of operation _____
Of autopsy none

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) _____

(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)
(e) Means of injury _____

23. Signature W. H. Wood (M. D. or other)

Address Grandview, Mo. Date signed 1-9-40

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 me

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

Signed E. H. Wise

Licensed Embalmer No. #2570

P. O. Address Kansas City

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.