

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10863

FILED APR 27 1940

Registration District No. 287 Primary Registration District No. 5405 Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Franklin Co. Mo.
 (b) City or town Reiner Mo.
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Dunklin
 (c) City or town Reiner Mo
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years

3. (a) PRINT FULL NAME WILLIAM HENRY EDWARDS
 3. (b) If veteran, name war _____ 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 Bettie Edwards 6. (c) Age of husband or wife if alive 43 years
 7. Birth date of deceased Nov 13 - 1893
 (Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month March day 28 - 1940
 year _____ hour 2 minute 30 P. M.
 21. I hereby certify that I attended the deceased from Unattended by a Physician
 that I last saw him alive on _____, 19____;
 and that death occurred on the date and hour stated above.

8. AGE: Years 46 Months 4 Days 15 If less than one day _____ hr. _____ min.

Immediate cause of death Coronary Thrombosis
 Due to _____
 Due to Over Exertion

9. Birthplace Dexter Mo (City, town, or county) (State or foreign country)

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

11. INDUSTRY OR BUSINESS
 10. Usual occupation Farmer
 12. Name A. L. Edwards
 13. Birthplace Mo (City, town, or county) (State or foreign country)
 14. Maiden name Margaret Norman
 15. Birthplace Mo (City, town, or county) (State or foreign country)

Major findings: Of operations _____
 Of autopsy _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Bettie Edwards
 (b) Address Reiner Mo
 17. (a) Removal (b) Date thereof 3-29-1940
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Springville Cem
 18. (a) Signature of funeral director Wm. H. Co
 (b) Address Reiner Mo
 19. (a) _____ (b) _____
 (Date received local registrar) (Registrar's signature)

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?
 23. Signature George Gilman D. M. D. (M. D. or other)
 Address Coroner of Dunklin Co. Mo Date signed 29

RECEIVED

District Health Officer No. 2

District File Number 440 94

Date Filed 4/12/00

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 A. C. Lansdell

Licensed Embalmer No. 818

P. O. Address Kennett 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10863

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 287

Primary Registration District No. 3405

Registrar's No. 12

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Dunklin

(b) City or town Clay

(c) Name of hospital or institution: _____
(If outside city or town limits, write "RURAL" and name of township)

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Wm Henry Edwards

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m

5. Color or race w

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 46 Months 4 Days 15 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 5/3/40 (b) L. B. Cope
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 28
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

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

Major findings: _____

Of operations _____

Of autopsy _____

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 Geo T. Gilmore (M. D. or other)

Address Kennett Mo Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

S-10863

1940