S.S.No. Unknown-if one

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

24904
Do not use this space.

3
0

1. PLACE OF DEATH
(a) County Clay — Registration District No. 198
(b) ~~Township~~ Fishing River — Primary Registration District No. 3011 — Registered No. 114
or
(c) City Excelsior Springs, Mo. (d) Street No. Veterans Administration Facility 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. 12 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 363 Thomas A. Edwards
(a) Residence, No. Grand Pass, Missouri St. ☐ Grand Pass, Missouri
(Usual place of abode, if no street address, write county or city) (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 (*write* the word): Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) December 19, 1877

7. AGE: YEARS 62 — MONTHS 7 6 — DAYS 6 — If LESS than 1 day, ... hrs. or ..... min.

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Saline County Missouri 0

FATHER
13. NAME David M. Edwards 0
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ? Missouri 1

MOTHER
15. MAIDEN NAME Ellen Fox
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ? Tennessee

17. INFORMANT (ADDRESS) Hospital Records ~~XXXXX~~

18. ~~BURIAL, CREMATION, OR~~ REMOVAL
PLACE Carrollton, Mo. DATE 7-26, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Claude Prichard Excelsior Springs, Mo. 180

20. FILED 7-27, 1940 Mrs Lea McCracken
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 25, 1940

22. I HEREBY CERTIFY, That I attended deceased from July 14, 1940, to July 25, 1940
I last saw him alive on July 25, 1940 Death is said to have occurred on the date stated above, at 2:05 P.M.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis with hypertension and cerebral accident	

Other contributory causes of importance: --

Name of operation none Date of
What test confirmed diagnosis? Examination and observation 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? Unknown
If so, specify
(Signed) W. A. Gerian, M. D.
(Address) W. A. GERIAN, M.D., Clinical Director Veterans Administration Facility Excelsior Springs, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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. 8
District File Number
Date Filed 8-8-40

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

Robert Ray, Registered Apprentice No. 226

working under my personal supervision.

Signed Claude Michael

Licensed Embalmer No. 2751

P. O. Address Excelsior Springs

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.