

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

FILED OCT 14 1942

Registrar's No. 254

Registration District No. 1

Primary Registration District No. 3000

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

1. PLACE OF DEATH: *Adair*

(a) County *Adair*

(b) City or town *Kelleville*

(c) Name of hospital or institution: *Green-Smith Hosp O*
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution *30 minutes*
(Specify whether years, months or days)

In this community _____

2. USUAL RESIDENCE OF DECEASED: *59*

(a) State *Missouri* (b) County *High*

(c) City or town *Edina (Rural)*
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME *Uphams Leona CANNON*

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Sept* day *29*
year *1942* hour *11* minute *15 P.M.*

4. Sex *F* 5. Color or race *wh* 6. (a) *3* Single, widowed, married, divorced, ~~married~~

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

7. Birth date of deceased: *Sept - 20 - 1896*
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from *9-29* 19*42* to *9-29* 19*42*
that I last saw h*er* alive on *9-29* and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
<i>46</i>	36	<i>0</i>	<i>9</i>	hr. _____ min.

Immediate cause of death: *Competitive heart failure*

Due to: *Ventricular fibrillation*

Due to _____

9. Birthplace: *Edina Missouri*
(City, town, or county) (State or foreign country)

Other conditions (include pregnancy within 3 months of death) *930*

10. Usual occupation: *Housekeeper*

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

11. Industry or business _____

12. Name: *Andrew Jackson Robertson*

13. Birthplace: *Sullivan, Missouri*
(City, town, or county) (State or foreign country)

14. Maiden name: *Emma Jane Muns*

15. Birthplace: *Edina Missouri*
(City, town, or county) (State or foreign country)

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? _____

16. (a) Informant: *Mrs Henry Robertson*

(b) Address: *Edina, Missouri*

17. (a) *Burial* (Burial, cremation, or removal) (b) Date thereof: *Oct-3-1942*
(Month) (Day) (Year)

(c) Place: burial or cremation: *Pleasant Ridge*

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

23. Signature: *E. S. Smith* (M. D. or other)
Address: *Kelleville* Date signed: *9/29/42*

18. (a) Signature of funeral director: *Keith Hudson*

(b) Address: *Edina, Missouri*

19. (a) *10/3/42* (Date received local registrar) (b) *Mrs. J. W. Wagner* (Registrar's signature)

RECEIVED

District Health Officer No. 10

District File Number 10-42-1870

Date Filed OCT 12 1942

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 Keith Hudson

Licensed Embalmer No. 2415

P. O. Address Edina 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, fact should be so stated above.