

STANDARD CERTIFICATE OF DEATH

DO NOT WRITE

FILED SEP 4 1943

STATE BOARD OF HEALTH

MO Dist. #

27623

Division of Vital Statistics, State of Kansas

21/18

Registrar's No. 50-805/161

IN THIS SPACE

1. PLACE OF DEATH

(a) County Bates  
(b) City or township West Boon  
(If outside city or town limits, write RURAL.)  
(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 \_\_\_\_\_ (Specify whether

In this community 6 yrs. years, months or days)

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.

3 (a) FULL NAME Pearl Ivy Wedge

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

4. Sex F 5. Color or race W 6 (a) Single, widowed, married, divorced 1 married

6 (b) Name of husband or wife Frank Wedge 6 (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased (Month) (Day) (Year) 8-27-1881

8. AGE: Years Months Days If less than one day  
62 10 15 hr. min.

9. Birthplace Port Scott Kans. (City, town or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Frank L. Davis

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

14. Maiden name Fanny Block

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

16 (a) Informant's own signature Frank Wedge

(b) Address Missouri Mo

17 (a) Burial (b) Date thereof 8-26-1943 (Burial, cremation or removal) (Month) (Day) (Year)

(c) Place: burial or cremation La Cynel Ks

18 (a) Signature of funeral director Chandler

(b) Address La Cynel Ks

19 (a) 8-26-43 (b) L. H. Mangold (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. Date of death: Month August day 23 year 1943 hour 10 P.M. minute 00

21. I hereby certify that I attended the deceased from 8-23 1943 to 8-23 1943 that I last saw her alive on August 21 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic nephritis 10 yrs? arterial sclerosis 10 yrs?

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 8 months of death) \_\_\_\_\_

Major findings: 131F  
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? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_  
23. Signature Chandler (M. D. or other) \_\_\_\_\_  
Address Paris Kansas Date signed \_\_\_\_\_

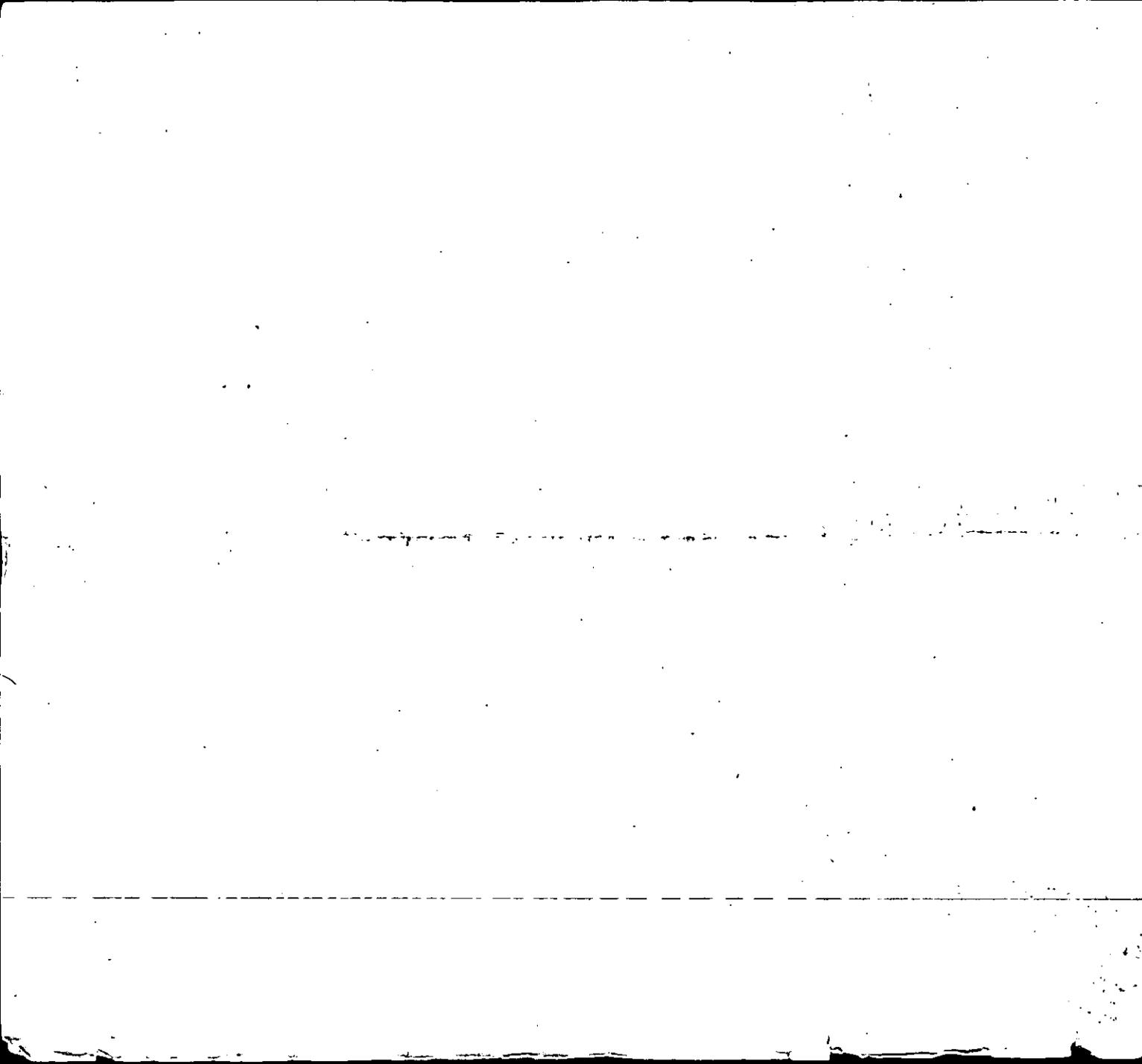
DURATION

PHYSICIAN

Underline the cause to which death should be charged statistically.

be properly classified. Exact statement of OCCUPATION is very important. 3-40-50M 18-3489-8

11300



THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 21

Primary Registration District No. 5100

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Bates  
(b) City or town West Boon  
(If outside city or town limits, write "RURAL" and name of township)  
(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 \_\_\_\_\_ (Specify whether  
in this community 6 yrs. years, months or days)

3. (a) PRINT FULL NAME Pearl Ivy Wedge  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 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 Feb 8 1885  
(Month) (Day) (Year)

8. AGE: Years 62 6 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country) Kans

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) L. H. Mangold  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Bates  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. West Boon Twp.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Year 1943 Hour \_\_\_\_\_ Minute 3 M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

27623