

FILED DEC 4 1946
199

Registration District No. _____

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town J. E. Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 3024 Troost Ave
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community 50 yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town J. E. Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 3024 Troost
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 18
year 1946 hour 7:50 P. minute M.

21. I hereby certify that I attended the deceased from February 28th, 1946, to Nov 18th, 1946
that I last saw him alive on Nov. 18th, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death: Cardiac Decompensation
Hypertension
Due to _____

Duration

5 mo

4 years

Due to _____
Due to _____
Other conditions: nutritional deprivation
(Include pregnancy within 8 months of death)

Major findings: _____
Of operations: _____

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 _____

Signature Joseph Beletore (M. D. or other) M.D.
Address 1619 Ruston Bldg Date signed 11-19-46

3. (a) PRINT FULL NAME

Gabrella W. Edwards

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Se / 5. Color or race Wh 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased Feb 22 - 1875
(Month) (Day) (Year)

8. AGE: Years 71 Months 8 Days 24 If less than one day _____ hr. _____ min.

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

10. Usual occupation seamstress

11. Industry or business self

12. Name Geo Wilson

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

14. Maiden name Mary C. Long

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

16. (a) Informant Mrs Wa-ne Laybourne

(b) Address 3024 Troost

17. (a) Burial (b) Date thereof 11-21-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Keytesville, Mo

18. (a) Signature of funeral director Chas Davidson

(b) Address 3024 Troost Ave
19. (a) 11-20-46 (b) Seraldine Holmes
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

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 *John W. Laybourn*
Licensed Embalmer No. *1715*

P. O. Address *K. C. 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.