

National Office of Vital Statistics
FILED APR 19 1948
Registration District No. **24**

Primary Registration District No. **3038**

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

1. PLACE OF DEATH:
(a) County Linn
(b) City or town Brookfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
304 W. Brooks St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 1/2 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Linn
(c) City or town Brookfield
(If outside city or town limits, write "RURAL")
(d) Street No. 219 Green Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME Jesse Winfield Scott Edens
3. (b) If veteran, name war None
3. (c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 5
year 1948 hour 2 minute 30 P. M.

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife Kitty Van Bibber
6. (c) Age of husband or wife if alive 1861 years
7. Birth date of deceased: June 19, 1861
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov, 1947, to April 5, 1948
that I last saw him alive on April 5, 1948
and that death occurred on the date and hour stated above.

8. AGE: Years 86 Months 9 Days 16
If less than one day hr. min.

Immediate cause of death
Acute myocarditis 48 hrs.
Due to Epithelioma on right side of neck 2 yrs.
Due to fractured hip 5 mos.
Other conditions:
(Include pregnancy within 3 months of death)

9. Birthplace: West Virginia
(City, town, or county) (State or foreign country)
10. Usual occupation Farmer - retired

Major findings:
Of operations 53
Of autopsy 53
ADDITIONAL SUPPLEMENTARY INFORMATION
Underline the cause of death which should be charged statistically.

11. Industry or business:
12. Name Jonathan Edens
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name Eliza Goff
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Roy Edens
(b) Address Brookfield, Mo.
17. (a) Burial (b) Date thereof 4-7-48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Jenkins Cem, Browning, Mo.

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

18. (a) Signature of funeral director Harold B. Wright
(b) Address Brookfield, Mo.
19. (a) 4-7-48 (b) Walter S. Craven
(Date received local registrar) (Registrar's signature) 11-7

23. Signature W. B. Simpson (M. D. or other) MD.
Address Brookfield, Mo. Date signed 4/5/48

**DISTRICT HEALTH OFFICE
Cameron, Mo.**

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..... *Harold B. Wright*.....
Licensed Embalmer No. 3718.....
P. O. Address Brookfield, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. may
Registrar's No. 38

Registration District No. 184 Primary Registration District No. 3038

1. PLACE OF DEATH:
(a) County Lin
(b) City or town Brookfield
(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..... years, months or days)

3. (a) PRINT FULL NAME Jesse W. S. Edema
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 wid
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased June 1918
(Month) (Day) (Year)

8. AGE: Years 86 Months Days If less than one day hr. min.

9. Birthplace W. Va.
(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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....

19. (a) (Data received local registrar) (b) (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) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month..... Day..... Year 1947 Hour..... minute..... M.
21. I hereby certify that I attended the deceased from..... to....., 19.....
that I last saw him..... 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) Dec 12 1947 fell walking across bed room floor at 11 PM - fracturing hip.
(b) Site of occurrence Brookfield, Lin. Mo.
(c) Where did injury occur? at home - Green St Brookfield Mo
(d) Did injury occur in or about home, on farm, industrial place, in public place? no
While at work? no (e) Means of injury fell
23. Signature W. B. Simpson (M. D. or other) DO
Address Brookfield Mo Date signed 4-23-48

SUPPLEMENTARY

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

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

S-13266