S. No. 2
M—8-43
5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 17 1948

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 29040

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 261

1. PLACE OF DEATH:

(a) County Callaway
(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital No 1. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 19 days. (Specify whether
In this community Same.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Shelby. 102
(c) City or town Shelbyville 0
(If outside city or town limits, write "RURAL") 1
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME LUTIE EDMONDS.
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F. 1
5. Color or race W
6. (a) Single, widowed, married, divorced M. 1
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased DK. (Month) (Day) (Year)

8. AGE: Years 70. Months Days If less than one day hr. min.

9. Birthplace D.K. (City, town, or county) 7 (State or foreign country)
10. Usual occupation Housework
11. Industry or business
FATHER
12. Name D.K. 9
13. Birthplace D.K. (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name D.K. 4
15. Birthplace D.K. (City, town, or county) 1 (State or foreign country)
16. (a) Informant Hospital Records.
(b) Address Fulton Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 8-31-48 (Month) (Day) (Year)
(c) Place: burial or cremation Shelbyville, Mo
18. (a) Signature of funeral director Wallace Funeral Home
(b) Address 7 W 6th St. Fulton Missouri
19. (a) 8-31-1948 (Date received local registrar) (b) Joan Morsinkoff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8. day 31
year 1948 hour 7 minute A. M.
21. I hereby certify that I attended the deceased from 8-20-48, 19, to 8-31-48, 19;
that I last saw her alive on 8-30-48, 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: inanition. Diabetes mellitus.	
~~Due to~~	
Due to	
Other conditions (Include pregnancy within 3 months of death) Generalized arteriosclerosis.	
Major findings: Of operations 61	
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?
(Specify type of place)
While at work? (e) Means of injury
23. Signature R. C. Price M.D. (M.D. or other)
Address Fulton Mo. Date signed 8-31-48
by H. Freyb.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number SEP 15 1948
Date Filed

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 Basil C Browning

Licensed Embalmer No. 27

P. O. Address Fulton 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.