No. 300
10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14922

FILED MAY 9 1953

BIRTH NO. _____ REG. DIST. NO. 182 PRIMARY REG. DIST. NO. 5686 Registrar's No. 12

0580
4

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

1. PLACE OF DEATH
a. COUNTY: Linn
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Linneus Mo.
c. LENGTH OF STAY (in this place): 4 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Turner Resthome

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo.
b. COUNTY: Linn
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Linneus 0580
d. STREET ADDRESS (If rural, give location): Mo. 0

3. NAME OF DECEASED (Type or Print): a. (First) Oscar b. (Middle) E. Edmonson c. (Last)

4. DATE OF DEATH (Month) (Day) (Year): April 28-1953

5. SEX: Male 0
6. COLOR OR RACE: White
7. ~~MARRIED, NEVER MARRIED, WIDOWED~~, DIVORCED (Specify): Divorced 3
8. DATE OF BIRTH: March 12-1876
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Rtd.
11. BIRTHPLACE (State or foreign country): Missouri 0
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: [redacted] Wm. Edmonson
13b. MOTHER'S MAIDEN NAME: Elmira Steel
14. NAME OF HUSBAND OR WIFE: Bessie Edmonson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: No
17. INFORMANT'S SIGNATURE OR NAME ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Chronic myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: 4222
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 17, 1953, *to* April 28, 1953, *that I last saw the deceased alive on* April 27, 1953, *and that death occurred at* 4 A. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Penton Wilson D.O.
23b. ADDRESS: Linneus, Mo.
23c. DATE SIGNED: April 29, 1953

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: May 1-1953
24c. NAME OF CEMETERY OR CREMATORY: Bethlehem
24d. LOCATION (City, town, or county) (State): Clark Co. Mo.

DATE REC'D BY LOCAL REG.: May 2-53
REGISTRAR'S SIGNATURE: Mrs. Budie Kelley 165
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Otis Quadling Kahoka Mo.

(Licensed Embalmer's Statement on Reverse Side)

JUN 12 1953

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.....

..... Student Embalmer No. .....

working under my personal supervision.

Student .....
Student Embalmer

Signed J. B. Brothers

Licensed Embalmer No. 1001

P. O. Address Jonesboro, Me.

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.