

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40998

STATE FILE NUMBER

FILED NOV 25 1957

Registration District No. 176 Primary Registration District No. 5656 Registrar's No. 24

1. PLACE OF DEATH a. COUNTY <u>Lawrence</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lawrence</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Holtzman Ozark</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Miller</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Residence</u> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>19.910</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>James</u> Last <u>Edwards</u>			4. DATE OF DEATH Month <u>11</u> Day <u>14</u> Year <u>1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-15-1888</u>
9. AGE (In years last birthday) <u>68</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>30</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Metcalf Co.</u>	11. BIRTHPLACE (City and state or country) <u>Ky</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>James B. Edwards</u>	
14. MOTHER'S MAIDEN NAME <u>Ermin Yates</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>none</u>	
16. SOCIAL SECURITY NO. <u>355-09-8377</u>		17. INFORMANT <u>Mrs. Edna Edwards Miller mo</u> Address <u>350X</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infection</u> <u>Pseudobulbar Palsy</u> <u>Chronic Paralysis Agitans</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>5 years</u> <u>5 years</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u></u> Month <u></u> Day <u></u> Year <u></u> a. m. <u></u> p. m. <u></u>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>Aug 14 1957</u> to <u>Nov 14 1957</u> and last saw ^{her} him alive on <u>Nov 13 1957</u> . Death occurred at <u>10:30</u> p. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Harold E. George D.O.</u>		22b. ADDRESS <u>Miller mo</u>	
22c. DATE SIGNED <u>11/16/57</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	
23b. DATE <u>11-16-1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Jordan Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Pence</u>		(State) <u>Indiana</u>	
24. FUNERAL DIRECTOR <u>Monnie Seiman</u> ADDRESS <u>Miller Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>11-23-57</u>	
26. REGISTRAR'S SIGNATURE <u>W. S. Bracey</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb
by me, ~~or by~~....., Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *L. R. Seiman*.....

Licensed Embalmer No. 329

P. O. Address *Miller*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.