

Health,  
& Welfare  
Public  
Health Service

S. 300  
v. 1-56

All  
diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.  
Securing the medical certification in the specific manner required by 193.140 MOKS 1949.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-025782  
STATE FILE NUMBER

FILED VS JUL 21 1959

Registration District No. 171 Primary Registration District No. 4267 Registrar's No. 33

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Odessa</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Odessa</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>209 E. Otway</u>			Length of stay in 1b <u>7 mos.</u>		d. STREET ADDRESS (If outside, give location) <u>209 E. Otway</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Billy</u> Middle <u>Lee</u> Last <u>Edwards</u>				4. DATE OF DEATH Month <u>J</u> Day <u>12</u> Year <u>1959</u>				
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 9, 1957</u>		9. AGE (In years last birthday) <u>1</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (City and state or country) <u>Richland, Mo.</u>		12. CITIZENSHIP OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Raymond Eugene Edwards</u>				14. MOTHER'S MAIDEN NAME <u>Shirley Sue Wilson</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. -----		17. INFORMANT Address <u>Raymond E. Edwards, Odessa, Mo.</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>Accident. Crushing injury to chest</u> <u>Child fell from immediate front porch</u> <u>unable to breathe. I did not see this child</u> <u>I was on an obstetric case at the time</u> <u>Dr. Watson was called &amp; gave me the phone number</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO <u>fall</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>I lowered pit man for a hot water tank tumbled on child</u>							INTERVAL BETWEEN ONSET AND DEATH <u>9100</u> <u>22</u>	
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input checked="" type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>I lowered pit man for a hot water tank tumbled on child</u>					
20c. TIME OF INJURY Hour <u>054</u> Month, Day, Year <u>July 12 1959</u>			20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>Home yard</u>	
20f. CITY, TOWN, OR LOCATION <u>Odessa</u>				COUNTY <u>Lafayette</u>		STATE <u>Mo</u>		
21. I attended the deceased from <u>never</u> to <u>never</u> and last saw him alive on <u>never</u> Death occurred at <u>about 11:00</u> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Dr. M. J. Watson</u> Coroner <u>3</u>				22b. ADDRESS <u>Odessa Mo</u>		22c. DATE SIGNED <u>7-15-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>7-14-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Richland cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Richland Mo.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Ralph O. Jones, Odessa, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>7-15-59</u>		26. REGISTRAR'S SIGNATURE <u>Emma Davidson</u>			

(Licensed Embalmer's Statement on Reverse Side)

4530

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.....  
Signature of Student Embalmer

Signed *Ralph O Jones*  
Licensed Embalmer No. *460*

P. O. Address *Odessa*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.