

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028106

FILED VS. AUG 24 1959

Registration District No. _____ Primary Registration District No. 4038 Registrar's No. 29

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>Benton</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>Benton</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>WARSAW</u>		Length of stay in 1b <u>3 days</u>		c. CITY OR TOWN <u>WARSAW</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>Warsaw Memorial Nursing Home</u>			Inside limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>8 miles N.W.</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JAKE</u> Middle _____ Last <u>EDWARDS</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>19</u> Year <u>1959</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>Jan 26, 1879</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>23</u>	IF UNDER 24 HR Hours _____ Min. _____	
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>Farm</u>		11. BIRTHPLACE (City and state or country) <u>Warsaw, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13a. FATHER'S NAME <u>Charles Edwards</u>			13b. MOTHER'S MAIDEN NAME <u>Jessie McBrinkman</u>			14. NAME OF HUSBAND OR WIFE <u>Julia Edwards</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. <u>none</u>		17. INFORMANT Address <u>Julia Wilson Edwards, Warsaw</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Acute circulatory failure</u>							<u>1 hr.</u>	
DUE TO (b) <u>Coronary thrombosis - myocardial infarct. 1 hr</u>								
DUE TO (c) <u>Arteriosclerosis</u>							<u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 _____ a.m. _____ p.m. Month, Day, Year _____			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>Jan., 10, 1954</u> to _____ and last saw her/him alive on <u>Aug. 19, 1959</u> Death occurred at <u>11:30 am</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Gussie Salyer DO</u>				22b. ADDRESS <u>Warsaw, Mo.</u>			22c. DATE SIGNED <u>8-20-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Aug 21, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Kirkwood Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Warsaw Benton Co, Mo</u>			
24. FUNERAL DIRECTOR ADDRESS <u>John F Reas Warsaw</u>			25. DATE RECD. BY LOCAL REG. <u>Aug 21 - 1959</u>		26. REGISTRAR'S SIGNATURE <u>Jas. A. Logan</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed John F. Reser

Licensed Embalmer No. 4098

P. O. Address Wawa

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.