

Registration District No. 37 Primary Registration District No. 5053 Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH**  
 (a) County Barry Washburn  
 (b) City or town \_\_\_\_\_  
 (c) Name of hospital or institution: \_\_\_\_\_  
Residence in Washburn  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 In this community 50 years 11 months  
 years, months or days

3. (a) PRINT FULL NAME CLEO WHITE EDENS  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White  
 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife Beverett Edens  
 6. (c) Age of husband or wife if alive 55 years  
 7. Birth date of deceased Sept. 11, 1890  
 (Month) (Day) (Year)

8. AGE: Years 50 Months 0 Days 10  
 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Washburn Missouri  
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Own Home

**MOTHER FATHER**  
 12. Name Thomas H. Hickey  
 13. Birthplace Unknown Tennessee  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Mandy Carbaugh  
 15. Birthplace Unknown Texas  
 (City, town, or county) (State or foreign country)

16. (a) Informant Beverett Edens  
 (b) Address Washburn, Mo.

17. (a) Burial (b) Date thereof 9-25-40  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washburn Primitive

18. (a) Signature of funeral director Keon Funeral Home  
 (b) Address Cassville, Mo.

19. (a) 9-25-1940 (b) John D. Frost  
 (Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Barry  
 (c) City or town Washburn  
 (If outside city or town limits write "RURAL")  
 (d) Street No. 0  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH, Month Sept. day 22<sup>nd</sup>  
 year 1940 hour 11 minute 45 P. M.  
 21. I hereby certify that I attended the deceased from Sept. 1939  
Sept., 1939, to Sept., 1940,  
 that I last saw her alive on Sept. 20, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Coronary Thrombosis  
 Due to \_\_\_\_\_  
Chronic Arterio-Sclerosis  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

PHYSICIAN  
 Major findings: \_\_\_\_\_  
 Of operations 94-10  
 Of autopsy \_\_\_\_\_  
 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? \_\_\_\_\_  
 While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
 23. Signature Dr. C. T. Brown (M. D. or other) 20  
 Address Beligman Mo. Date Sept 22, 1940

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

Reg 37  
Pri 5053

RECEIVED

District Health Officer No. 6,

District File Number 1040-2739

Date Filed ~~OCT 14 1940~~ OCT 14 1940

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.....

*Eugene Wood*

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Eugene Wood*

Licensed Embalmer No.....

*3804*

P. O. Address.....

*Cassville, 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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **31208**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **37**

Primary Registration District No. **2053**

Registrar's No. \_\_\_\_\_

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

1. PLACE OF BIRTH:

(a) County **Barry**

(b) City or town **Washburn**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community **life** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Cleo. white Edens**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **m**

6. (b) Name of husband or wife **N.E. Edens** 6. (c) Age of husband, or wife, if alive **55** years

7. Birth date of deceased **9/11** (Month) (Day) (Year) **1890**

8. AGE:

Years	Months	Days	If less than one day
<b>50</b>	<b>0</b>	<b>11</b>	hr. min.

9. Birthplace **Washburn** (City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business \_\_\_\_\_

12. Name **Thomas Viehey**

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name **Amanda Carbaugh**

15. Birthplace **Idaho** (City, town, or county) (State or foreign country)

16. (a) Informant **N.E. Edens**

(b) Address **Washburn, Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **10/25/40** (Month) (Day) (Year)

(c) Place: burial or cremation **Washburn Prairie**

18. (a) Signature of funeral director **Koon Funeral Home**

(b) Address **Cassville, Mo.**

19. (a) **11/19/40** (Date received local registrar) (b) **Fred Edens** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

20. DATE OF DEATH: Month **Sept** day **22** year **1940** hour **11** minute **15 P.** M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw her alive on **Sept. 22** and that death occurred on the date and hour stated above.

Immediate cause of death **Heart trouble**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 **E. P. Brown** (M. D. or other) Address **Belgium** Date signed \_\_\_\_\_

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

