

MAR 19 1928

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

8374

1. PLACE OF DEATH

County Daniels
Township Jackson
City _____ (No. _____) St. _____ Ward _____

Registration District No. 253
Primary Registration District No. 5351

File No. _____
Registered No. _____

2. FULL NAME

Anna Mae Edwards

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) _____

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Bohy

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 17 - 1927

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
2 7 6

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Mo.

10. NAME OF FATHER Bohy M. Edwards

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Kansas

12. MAIDEN NAME OF MOTHER Dora T. Edwards

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mo.

14. INFORMANT W. J. Edwards
(Address) Cherry Street, N. E.

15. FILED 3/5 28 1928 R. M. McCoy REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 4th 1928

17. I HEREBY CERTIFY That I attended deceased from Feb 4th 1928 to Feb 4th 1928 that I last saw her alive on Feb 4th 1928; and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

9
100% Pneumonia
(duration) _____ yrs. _____ mos. _____ da.

CONTRIBUTORY Hooping Cough
(SECONDARY) (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED Home
IF NOT AT PLACE OF DEATH: _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physical Exam
(Signed) G. H. Schaeffer, M. D.
, 19 _____ (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS and NATURE of INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

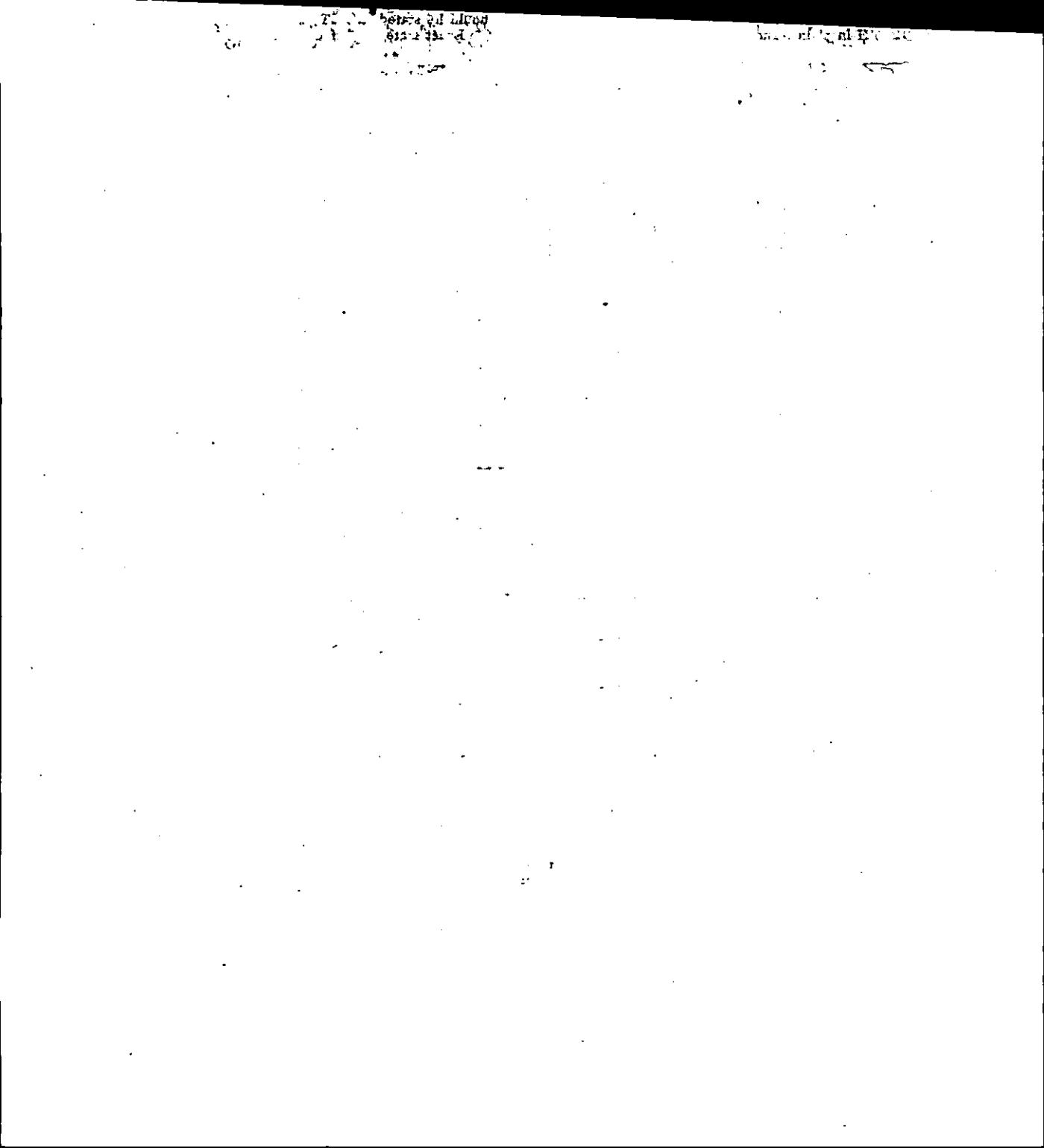
19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
Common Church Cemetery B-15 1928

20. UNDERTAKER None ADDRESS _____

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. PHYSICIANS should state cause of death as accurately as possible.

... 75 ...
... 20 ...
... 10 ...
... 5 ...

... of ...



**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Ladue Registration District No. 253 File No. 3
Township Jackson Primary Registration District No. 5251 Registered No. _____
City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Anna Mae Edwards

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Baby. Dec 17 - 1927

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
- 2 16

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER Roy M. Edwards

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mo.
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Anna F. Edwards

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo.
(STATE OR COUNTRY)

14. INFORMANT W. E. Edwards
(Address) Jamesport Mo.

15. FILED Jan 10 1928 A. G. Minnich
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 4 1928

17. I HEREBY CERTIFY That I attended deceased from 2-4 to 2-4, 1928
that I last saw h. at home of 2-4, 1928 and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia
CONTRIBUTORY Hooping Cough
(SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no. DATE OF _____

WAS THERE AN AUTOPSY? no.

WHAT TEST CONFIRMED DIAGNOSIS? Physical Exam
(Signed) E. H. Ford Cliffe M. D.
Mar 5, 1928 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Corner Church Cem. DATE OF BURIAL 3-5 1928

20. UNDERTAKER none ADDRESS _____

CAUSE OF DEATH should be carefully supplied. AGE should be EXACTLY. PHYSICIANS should state their terms, so that it may be properly classified. REGISTRATION is very important. REGISTRARS SHOULD RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-8374