

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

Do not use this space.

12801

1. PLACE OF DEATH

County..... *Jackson*

Registration District No. *399*

Township..... *Law*

Primary Registration District No. *1*

City..... *Kansas City (No. 1)*

Registered No. *1730* (Ward)

2. FULL NAME

Alton Chalmers Edrington

(a) Residence. No. *315 W. 9th* St., Ward.

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

separated

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Unknown

7. AGE

Unknown

If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Darnall

(b) General nature of industry, business, or establishment in which employed (or employer)

Realty Co

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

N.Y.

10. NAME OF FATHER

Dell Lou Edrington

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

N.Y.

12. MAIDEN NAME OF MOTHER

Sally M. Durbin

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown

14.

INFORMANT
(Address)

*Leah Ruel Edrington
St Louis Mo*

15.

FILED

4/21 1930 M.M. Crowe

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Monday 4-21 1930*

17. I HEREBY CERTIFY, That attended deceased from....., 19..... to....., 19.....

that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis

CONTRIBUTORY (SECONDARY)

Chronic Pericarditis
(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? *yes*

WHAT TEST CONFIRMED DIAGNOSIS? *Autopsy*

(Signed) *Stanley M. Crowe* M. D.

4/21 1930 (Address) *Deputy Coroner*

*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

Culvers Madestahere

4-22 1930

20. UNDERTAKER

ADDRESS

Butler Mo

Butler Mo

WHITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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