NOV 22 1930

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

Do not use this space.

29601

File No. .....

Registered No. .....

1. PLACE OF DEATH

County GREENE Registration District No. 317

Township BROOKLINE Primary Registration District No. 5441

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME NANCY.L.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: FEMALE

4. COLOR OR RACE: WHITE

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) JUNE 22 1869

7. AGE: Years 61 | Months 3 | Days 8 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work HOUSE WIFE
(b) General nature of industry, business, or establishment in which employed (or employer) HOUSE WORK
(c) Name of employer

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

PARENTS

10. NAME OF FATHER T.B.KELTNER

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

12. MAIDEN NAME OF MOTHER SARAH.PERKINS

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

14. INFORMANT Birdie E. Edwards
(Address) Brookline - mo.

15. FILED 10/1, 1930 H. G. Frame
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 30 1930

17. I HEREBY CERTIFY, That I attended deceased from March 30, 1929, to Sept. 23, 1930, that I last saw h. alive on Sept. 30, 1930, and that death occurred, on the date stated above, at 2 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis
23A

..... (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

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

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) U. S. French, M. D
, 19 (Address) Republic mo

*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: Mosley Cemetery — DATE OF BURIAL: 10/2 1930

20. UNDERTAKER: Pat Simmon — ADDRESS: Republic

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.