

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

Do not use this space.

27917

1. PLACE OF DEATH

County Franklin
Township Union
City (No. _____) _____

Registration District No. 282
Primary Registration District No. 5401

File No. _____
Registered No. 34
St. _____ Ward _____

2. FULL NAME

Marquette Melvina 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 <u>Female</u> | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>1</u> |
| 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Thomas Edwards</u> | | |
| 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Mar 9 1863</u> | | |
| 7. AGE, YEARS <u>78</u> | MONTHS <u>5</u> | DAYS <u>10</u> |
| 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>none</u> | | 11. Total time (years) spent in this occupation |
| 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. | | 10. Date deceased last worked at this occupation (month and year) |

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pector Ark.

FATHER 13. NAME George Lynch

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

MOTHER 15. MAIDEN NAME Peggie Ford

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

17. INFORMANT (ADDRESS) J. A. Edwards

18. BURIAL, CREMATION, OR REMOVAL PLACE Abbeville DATE 8/21 1931

19. UNDERTAKER (ADDRESS) Edwards

20. FILED 8/20 1931 Edwards Registrar.

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 19 1931

22. I HEREBY CERTIFY, That I attended deceased from 8-11 1931 to 8-19 1931

I last saw him alive on 8-11 1931. Death is said

to have occurred on the date stated above, at 6 P m.

The principal cause of death and related causes of importance were as follows:

Gastric hemorrhage Date of onset 8-15-31
Senility

Name of operation _____ Date of _____

What test confirmed diagnosis? Stamps Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 1931

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

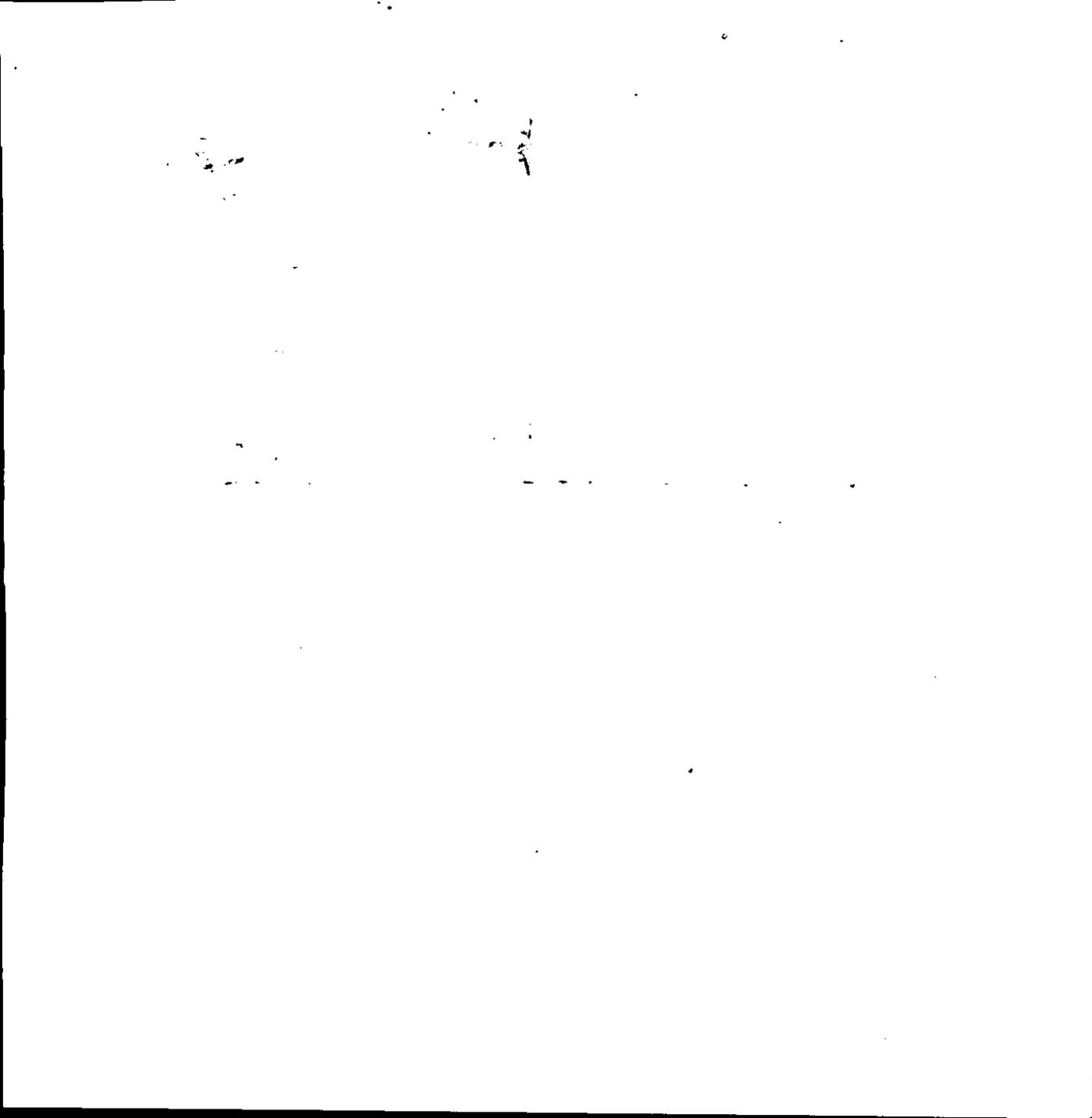
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? ns

If so, specify _____

(Signed) J. F. Reynolds M. D.

(Address) Abbeville Mo.



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ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Dunklin Registration District No. 282 File No. _____
Township Union Primary Registration District No. 5401 Registered No. 34
City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Marguerite Melvina 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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 9 - 1853

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
78 5 10

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____ (duration) yrs. mos. ds.
(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) _____

10. NAME OF FATHER _____

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

12. MAIDEN NAME OF MOTHER _____

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

14. INFORMANT (Address) _____

15. FILED 8/20, 1931 E W Lander REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 19 1931

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Sustained hemorrhage
x - attack to gastric
ulcers

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

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

DID AN OPERATION PRECEDE DEATH _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS _____
(Signed) J. H. Thacker, M. D.
, 19____ (Address) Bonnie, 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 _____ DATE OF BURIAL _____ 19____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED

5-27917