WRITE 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.

MAY 25 1934

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 Kaw — Primary Registration District No. 1002 — File No.
City Kansas City (No. 410, West 9th St. St. Ward) — Registered No.

2. FULL NAME Ray Casparus Edwards
(a) Residence, No. 510 West 9th 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: Male
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: Ruth Edwards
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): April 24 - 1897
7. AGE: YEARS 36 — MONTHS 11 — DAYS 9 — If LESS than 1 day, ... hrs. or ... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Upholster
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)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Minnesota

FATHER
13. NAME: ~~[illegible]~~ Bert Edwards
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Minn.

MOTHER
15. MAIDEN NAME: Katharine Casparus
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Minn.

17. INFORMANT (ADDRESS): Ruth Edwards, 510 West 9th St.
18. BURIAL, CREMATION, OR REMOVAL PLACE: Mt. Hope DATE: 4-6-34
19. UNDERTAKER (ADDRESS): Mrs C R Forster, 914 Brooklyn
20. FILED: Apr 5, 1934 M. M. Crowe, Asst. Registrar.

MEDICAL CERTIFICATE OF DEATH

3

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 4/3/34, 19
22. I HEREBY CERTIFY: That I attended deceased from Deputy Coroner, 19 to , 19
I last saw h alive on , 19 . Death is said to have occurred on the date stated above, 2 A m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Automobile hemorrhagic lesion	
Laceration of scalp	
Concussion of the brain	
Acute Cerebral edema	

Other contributory causes of importance:

No 210

Name of operation: Date of
What test confirmed diagnosis: Autopsy 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: 4/2/34
Where did injury occur? Sedalia Mo (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury: Car overturned
Nature of injury: Cerebral
24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) [signature] M. D.
(Address) [signature]