

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.

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

Do not use this space.

APR 17 1935

8757

1. PLACE OF DEATH

County GreeneRegistration District No. 318

Township

Primary Registration District No. 2001City Springfield, Mo.610 Mt Vernon

File No.

Registered No. 61

2. FULL NAME

William H. Edmond(a) Residence, No. 610 Mt Vernon Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 3 yrs. ds. How long in U. S., if of foreign birth? yrs. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF Hellie Edmond6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 15-1862

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>72</u>	<u>10</u>	<u>17</u>		

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired farmer

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) Utich N. Y.13. NAME Atkinson14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Atkinson15. MAIDEN NAME Atkinson16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Atkinson17. INFORMANT (ADDRESS) Mr. F. H. Parker18. BURIAL, CREMATION, OR REMOVAL PLACE Green Lawn DATE March 5, 193519. UNDERTAKER (ADDRESS) F. C. Phigins20. FILED 3-5 1935 R. P. Whang Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 2, 193522. I HEREBY CERTIFY, That I attended deceased from Jan 27, 1935, to Mar 2, 1935.I last saw him alive on Mar 1, 1934. Death is saidto have occurred on the date stated above, at 7:30 a.m.

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

Pneumonia hypostatic Date of onset 2-27-35Other contributory causes of importance: Neurovasc Central 1-27-35Name of operation Date of What test confirmed diagnosis? clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury 19.....

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? no If so, specify(Signed) Reggie R. West, M. D.(Address) Springfield, Mo.

MAY 24 1935

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

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1. PLACE OF DEATH

County Greene
 Township.....
 City..... (No.....)

Registration District No. 318
 Primary Registration District No. 2001

File No.....
 Registered No. 61
 St..... Ward.....

2. FULL NAME

William H. Edmund

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

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 m **4. COLOR OR RACE** w **5. SINGLE, MARRIED, WIDOWED, OR DIVORCED** (write the word) m

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
72 10 17

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

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)

FATHER
13. NAME

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

MOTHER
15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE..... DATE..... 19.....

19. UNDERTAKER (ADDRESS)

20. FILED 59 1935 Ralph H. ... Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 2, 1935

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

I last saw h..... on....., 19..... Death is said to have occurred on the date stated above, at..... m.

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

Hyphartate pneumonia
Labat

Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... 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....., 19.....

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?.....

If so, specify.....

(Signed)....., M. D.

(Address).....

N. E. 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 16 1963

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