

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.

SEP 21 1937

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

Do not use this space.

29825

1. PLACE OF DEATH

County Jackson  
Township Raw  
City Panasosky

Registration District No. 300  
Primary Registration District No. 15, 2  
(No. Northeast Hospital)

File No. \_\_\_\_\_  
Registered No. 350  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

Robert James Edwards

(a) Residence, No. 2829 Baltimore 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. 2 How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 8/16/37

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min. 2

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. none  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Infant  
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) Kansas City Mo

13. NAME Thomas Henry Edwards  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Organ, Mo.

15. MAIDEN NAME Bernice Patricia Maguire  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Paul, Minn.

17. INFORMANT (ADDRESS) Mother, Bernice Edwards  
2829 Baltimore

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Paul, Minn. DATE Aug. 21, 1937

19. UNDERTAKER (ADDRESS) J. F. O'Donnell Co  
3256 Broadway

20. FILED Aug. 20, 1937 M. M. Crowe, cash  
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 18, 1937

22. I HEREBY CERTIFY, That I attended deceased from Aug. 16, 1937, to Aug. 18, 1937

I last saw him alive on Aug. 18, 1937 Death is said to have occurred on the date stated above, at 11:52 a.m.

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

Congenital malformation of Heart

157c

Other contributory causes of importance: Failure of Foramen Ovale to close

Name 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? If so, specify \_\_\_\_\_

(Signed) Chas. F. McArthur, M.D.  
(Address) 500 Buford Bldg, K.C., Mo.

