

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

**38703**

Do not use this space.

DEC 15 1938

**1. PLACE OF DEATH**

(a) County BUCHANAN Registration District No. 86  
 (b) Township WASHINGTON Primary Registration District No. 5127  
 (c) City ST. JOSEPH (d) Street No. R.F.D.#1 St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

Registered No. 61

**2. PRINT FULL NAME** 352 JAMES H. EDMISTON

(a) Residence, No. R.F.D.#1 St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX MALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) SINGLE

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF NONE

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) MARCH 30, 1868

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
70 7 21

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. FARMER  
 9. Industry or business in which work was done, as 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) KING CITY, MISSOURI

FATHER 13. NAME JOHN EDMISTON

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) NORTH CAROLINA, I

MOTHER 15. MAIDEN NAME REBECCA FROGGE,

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

17. INFORMANT (ADDRESS) J. T. Edmiston R.F.D.#1 St. Joseph

18. BURIAL, CREMATION, OR REMOVAL PLACE Courtesy Ave DATE Nov. 22, 1938

19. FUNERAL DIRECTOR (ADDRESS) FLEEMAN & SON INC. 1946 COLHOUN ST. ST. JOSEPH, MO.

20. FILED Nov. 21, 1938 Myrtle M. Harrison 861 Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) NOV. 21, 1938, 19

22. I HEREBY CERTIFY, That I attended deceased from II/21, 1938 to 11/21, 1938

I last saw him alive on 11/21, 1938 Death is said to have occurred on the date stated above, at 5:30 p.m.

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

Suicide by fire arms

Date of onset

Other contributory causes of importance: none

Name of operation Date of

What test confirmed diagnosis? History Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? suicide Date of injury II/21, 1938

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

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

Manner of injury. Shot through head

Nature of injury. Brain lesion

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify (Signature) R. W. Tadlock Coroner, M. D.

(Address) King Hill Bldg

WHITE PLAIN, WITH UNFOLDING INSTRUMENTS 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.

I X12004

**STATEMENT BY LICENSED EMBALMER**

I, JOHN E. RUPP, Licensed Embalmer No. 3986

hereby certify that the body recorded on the reverse side of this certificate was embalmed by MYSELF

L. E.

No. \_\_\_\_\_ or by \_\_\_\_\_ Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed

*John E. Rupp*

Licensed Embalmer No. 3986

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

38709  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Buchanan Registration District No. 86  
 (b) Township Washington Primary Registration District No. 5127 Registered No. 61  
 (c) City..... (d) Street No..... St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME James Edmiston  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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. or _____ min.
	<u>70</u>	<u>7</u>	<u>21</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_

9. Industry or business in which work was done, as 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) unknown

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19 \_\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

20. FILED Jan 10 1939 Myrtle M. Hanson Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 21 1938

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

I last saw h. \_\_\_\_\_ alive 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:

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) B. W. Tadlock, M. D.  
 (Address) Living Hill Bldg

Date of onset \_\_\_\_\_

SUPPLEMENTARY

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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