REC'D APR 11 1939

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

10088
Do not use this space.

1. PLACE OF DEATH
(a) County BUCHANAN
(b) Township ~~WASHINGTON~~
(c) City ST. JOSEPH,
Registration District No. 85
Primary Registration District No. 1001
Registered No. 243
(d) Street No. MISSOURI M.E. HOSPITAL 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 UNK yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

11/5/7

363

2. PRINT FULL NAME MRS. CORA EDWARDS
(a) Residence, No. R.F.D.#5 ST. JOSEPH, MO. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FEMALE
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 JAMES ELRICK EDWARDS

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 28, 1899

7. AGE: Years 39 | Months 4 | Days 17 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. HOUSEWIFE
9. Industry or business in which work was done, as saw mill, bank, etc. HOME
10. Date deceased last worked at this occupation (month and year) TWO WEEKS AGO
11. Total time (years) spent in this occupation UNK

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) LINN COUNTY, MISSOURI

FATHER
13. NAME ANDREW J. WATSON,
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) LINN CO. MO.

MOTHER
15. MAIDEN NAME FLORENCE E. GODDARD,
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) LINN CO. MO.

17. INFORMANT JAMES ELRICK EDWARDS
(ADDRESS) R.F.D.#5 ST. JOSEPH, MO.

18. BURIAL, CREMATION, OR REMOVAL
PLACE ASHLAND CEMETERY, DATE MARCH 13, 1939

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

20. FILED Mar. 13, 1939 H. J. Nestlebush Local Registrar.
RB

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) MARCH 9, 1939

22. I HEREBY CERTIFY, That I attended deceased from Feb 23, 1939, to March 9, 1939
I last saw h. ER alive on March 9, 1939. Death is said to have occurred on the date stated above, at 10:44 P.M.
The principal cause of death and related causes of importance were as follows:

Peritonitis, general — Date of onset 2/23/39

Other contributory causes of importance:
Acute gangrenous appendicitis — 2/23/39
Post operative psychosis — 3/2/39

Name of operation Laparotomy and appendectomy Date of 2/25/39
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) C. S. Grant M.D., M. D.
(Address) St. Joseph, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.

I X14028

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, JOHN E. RUPP,

....., or by .....,

Registered Apprentice No....., working under my personal supervision.

Signed John E. Rupp

Licensed Embalmer No. 3986

P. O. Address St. Joseph

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.)

If this body is not embalmed, above space should be left blank.