REG'D APR 15 1939

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

15090
Do not use this space.

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.

1. PLACE OF DEATH
(a) County Jackson — Registration District No. 400
(b) Township Prairie — Primary Registration District No. 5553 — Registered No. 64
(c) City Little Blue Mo (d) Street Name Jackson Co Home 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 1 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
543

2. PRINT FULL NAME AGNES EDWARDS
(a) Residence, No. 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: Fe
4. COLOR OR RACE: negro
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Don't Know

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

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

7. AGE: YEARS: about 35 | MONTHS | DAYS | If LESS than 1 day, hrs. or min.

OCCUPATION
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.: unemployed
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): Don't Know

FATHER
13. NAME: Don't Know
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mo

MOTHER
15. MAIDEN NAME: Don't Know
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Don't Know

17. INFORMANT (ADDRESS): County Home Records, Little Blue Mo

18. BURIAL, CREMATION, OR REMOVAL: 3-8-39
K.C. College of Osteopathy, 19

19. FUNERAL DIRECTOR (NAME) (ADDRESS): Flynn & Greenstreet, K.C. Mo

20. FILED Apr 7, 1939 William J. Fields, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-6-39, 19 — 4:15 a.m.

22. I HEREBY CERTIFY, That I attended deceased from Nov 1, 1938, to Feb 6, 1939
I last saw h alive on 3-6-, 1939. Death is said to have occurred on the date stated above, at 4:11 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	
Cystitis, B.C.D.	

Other contributory causes of importance:
Operation
"No further information"
Name of operation — Date of
What test confirmed diagnosis? 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) L. W. Booker, M. D.
(Address) 2028 Vine St.

(Licensed Embalmer's Statement on Reverse Side)

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, ...

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

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

Signed Edw G Evans

Licensed Embalmer No. 3836

P. O. Address 1819 E 15th St N.C. NC

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.