

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

29728
Do not use this space.

SEP 6 1939

1. PLACE OF DEATH

(a) County Mississippi Registration District No. 576
 (b) Township Wyatt Primary Registration District No. 5762 Registered No. 88
 (c) City Mad Wyatt (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

Marshall E. Edwards
 (a) Residence, No. Wyatt, Mo Box 374 St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Color 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Delie Edwards
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 25, 1873

7. AGE YEARS 66 MONTHS 5 DAYS 2 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. Minister
 10. Date deceased last worked at this occupation (month and year) 8/27/39 11. Total time (years) spent in this occupation 20

12. BIRTHPLACE (CITY OR TOWN) Nittisuma (STATE OR COUNTRY) Mississippi

FATHER 13. NAME Ed Edwards

14. BIRTHPLACE (CITY OR TOWN) Azure County (STATE OR COUNTRY) Miss

MOTHER 15. MAIDEN NAME Elyzabeth Williams

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

17. INFORMANT (ADDRESS) Delie Edwards
Wyatt Mo Box 374

18. BURIAL, CREMATION OR REMOVAL PLACE Oak Grove Cemetery Charleston Mo 8/31 1939

19. FUNERAL DIRECTOR (NAME) Lair Russell Turner (ADDRESS) Charleston, Mo Service

20. FILED 8-29-1939 J. D. Vernon Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8/27 1939

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.
 I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at 4:00 P.M.
 The principal cause of death and related causes of importance were as follows:
from history of case this man died of heart failure due to
Metabolic Insufficiency
 Date of onset _____

Other contributory causes of importance: 92 u

Name of operation none Date of _____
 What test confirmed diagnosis? Diagn 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? No
 If so, specify _____
 (Signed) Frank D. Vernon M. D.
Charleston Mo (Address) 8/27/39

RECEIVED

District Health Officer No. 2

District File Number 939-170

Date Filed 9-2

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 John P. Funnelle Jr

Licensed Embalmer No. 3851

P. O. Address Charleston W

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.