

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

2182
 Do not use this space.

1. PLACE OF DEATH **Fifth Feb 25 1940**

(a) County Crawford Registration District No. 231
 (b) Township _____ Primary Registration District No. 4141
 (c) City Shelbille Mo (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 Eliva Gibson Edger

(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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 5-1862

7. AGE YEARS 78 MONTHS 9 DAYS 5 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. Man
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) Crawford Mo (STATE OR COUNTRY) _____

FATHER

13. NAME Ora Pitcock
 14. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

MOTHER

15. MAIDEN NAME Malinda
 16. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

17. INFORMANT Ms Nellie Edgerton
 (ADDRESS) 404 Howard Drive

18. BURIAL, CREMATION, OR REMOVAL buried Greenwood
 PLACE Shelbille County DATE 1/12, 1940

19. FUNERAL DIRECTOR (NAME) F. J. James
 (ADDRESS) Shelbille Mo.

20. FILED 2-8, 1940 A. K. White
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/10, 1940

22. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1939, to Jan 10, 1940
 I last saw him alive on Jan 7, 1941. Death is said to have occurred on the date stated above, at 10:30 a. m.
 The principal cause of death and related causes of importance were as follows:
Chronic Nephrosis
disease of heart
 Date of onset _____

Other contributory causes of importance: g. d. w.

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) R. G. Parker, M. D.
207 (Address) Shelbille Mo.

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.

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.

RECEIVED
District Health Officer No. 5,

District File Number 240207

Date Filed 21440

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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CERTIFICATE OF DEATH

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Do not use this space.

1. PLACE OF DEATH

(a) County Crawford Registration District No. 231
(b) Township _____ Primary Registration District No. 4171 Registered No. _____
(c) City Steckville (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

Elvin Gibson Edger
(a) Residence, No. _____ St. 9
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED wed

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-10 1940

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

22. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____

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

I last saw h..... alive on..... 19..... Death is said to have occurred on the date stated above, at..... m.

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
28 9 5

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

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

Date of onset

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

Other contributory causes of importance:

FATHER 13. NAME

Name of operation..... Date of.....

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

What test confirmed diagnosis?..... Was there an autopsy?.....

MOTHER 15. MAIDEN NAME

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury..... 19.....

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

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

17. INFORMANT (ADDRESS)

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

18. BURIAL, CREMATION, OR REMOVAL

Manner of injury.....

PLACE _____ DATE _____ 19____

Nature of injury.....

19. FUNERAL DIRECTOR (ADDRESS)

24. Was disease or injury in any way related to occupation of deceased?.....

20. FILED 2-8 1940

If so, specify

(Signed) R. C. Parker, M. D.

(Address) Steckville Mo

Local Registrar.

SUPPLEMENTARY

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.

