DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 14583

MAY 15 1940

Registration District No. 163

Primary Registration District No. 5298

Registrar's No. 27

1. PLACE OF DEATH:
(a) County CEDAR Box. Twp.
(b) ~~City or town~~ RURAL "
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County CEDAR
(c) City or town RURAL
(If outside city or town limits, write "RURAL")
(d) Street No. R.F.D. # 2, Box. Twp.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME ERMA BEDFORD 316

3. (b) If veteran, name war —

3. (c) Social Security No.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife George Bedford

6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased Feby (Month) — 1 (Day) — 1905 (Year)

8. AGE: Years 35 | Months 2 | Days 16 | If less than one day ___ hr. ___ min.

9. Birthplace Slater (City, town, or county) Mo (State or foreign country)

10. Usual occupation housewife

11. Industry or business

FATHER
12. Name W.H. Bailey
13. Birthplace (City, town, or county) mo (State or foreign country)

MOTHER
14. Maiden name Nelly Sheppard
15. Birthplace (City, town, or county) mo (State or foreign country)

16. (a) Informant George Bedford
(b) Address Eldorado Springs. mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-18-1940 (Month) (Day) (Year)
(c) Place: burial or cremation Sandridge (Cem)

18. (a) Signature of funeral director Gwynn Sisler
(b) Address Eldorado Springs. mo.

19. (a) 4/18/40 (Date received by local registrar) (b) G.W. Stevenson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 17
year 1940 7 a. hour minute 7. a. M.

21. I hereby certify that I attended the deceased from May 1, 1939, to April 17, 1940
that I last saw her alive on April 16, 1940
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Septicemia	6 wks.
Due to: Influenza	
Due to: Lobar Pneumonia	
Other conditions: Leucea (Include pregnancy within 3 months of death)	

Major findings:
Of operations 34
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
154 (Specify type of place)
While at work? (e) Means of injury

23. Signature Wm J. McGee (M. D. ~~coroner~~)
Address El Dorado Springs Date signed 4/17/40

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:
(a) County _____
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify weeks, days or years) In this community _____

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ Years

PRINT
FULL NAME

3. (a) Veteran of what war? _____ (b) Veteran's Serial No. _____ 5. (c) Social Security No. _____

4. Sex _____ 6. Color or race _____ 6. (a) Single, widowed, married, divorced _____

5. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____ year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h___ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration

Due to _____

Due to _____

Due to _____

(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Birthplace _____ Registered Apprentice No. _____

13. Maiden name _____

14. Birthplace _____

15. Signed _____

16. Licensed Embalmer No. 3-230

17. (a) Date signed _____ (Month) (Day) (Year) (b) Date entered _____

18. P. O. Address _____

19. (a) _____ (b) _____
(Date received for registration) (Registrar's signature)

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 _____ working under my personal supervision.

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.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5-46-29