

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **15575**

Registration District No. **165** Primary Registration District No. **2289** Registrar's No. _____

1. PLACE OF DEATH:
(a) County New Madrid Co., Mo.
(b) City or town Bernie R 70
(c) Name of hospital or institution
(If outside city or town limits, write "RURAL" and name of township)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Evelyn Edwards 363
8. (b) If veteran, name war
8. (c) Social Security No.

4. Sex 2
5. Color or race W
6. (a) Single, widowed, married, divorced —
6. (b) Name of husband or wife Wm Edwards
6. (c) Age of husband or wife if alive 32 years
7. Birth date of deceased Dec 27 1911
(Month) (Day) (Year)

8. AGE: Years 29 Months 8 Days 1
If less than one day _____ hr. _____ min.

9. Birthplace Pocahontas Ark.
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business At Home

12. Name Alvin Irene

13. Birthplace Ida
(City, town, or county) (State or foreign country)

14. Maiden name Clara Burns

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

16. (a) Informant's own signature Evelyn Edwards

(b) Address Bernie Mo R 70

17. (a) Bernie (b) Date thereof 4 29 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Taylor Cem

18. (a) Signature of funeral director Pi Chicks

(b) Address New Madrid Mo

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County New Madrid
(c) City or town Bernie Mo R 70
(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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 4 day 28
year _____ hour 30 a minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that I last saw him alive on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Embolism!
Duration _____
Died Before Physician
Due to Arrived
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: _____
Of operations _____
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? 534
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature [Signature] (M. D. or other) _____
Address [Address] Date signed _____

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.

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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.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15-5-73-

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 005-

Primary Registration District No. 4359

Registrar's No. _____

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Como, T.P.
(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 whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Evelyn Edwards

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased Dec 27 1911
(Month) (Day) (Year)

8. AGE: Years 28 Months 4 Days 1 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 6-8-40 (b) J. Brown
(Date received local registrar) (Registrar's signature)

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.

LEGAL CERTIFICATION

20. DATE OF DEATH Month 4 day 28
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____
_____ 19 _____ to _____ 19 _____
that I last saw him _____ alive on _____ 19 _____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature M. J. Huff (M. D. or other)

Address _____ date signed _____

SUPPLEMENTARY

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

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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 153-75-7

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 605

Primary Registration District No. 4359

Registrar's No.

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

1. PLACE OF DEATH:

(a) County: New Madrid

(b) City or town: Camdenton
(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 whether
In this community _____ years, months or days)

3. (a) PRINCE
FULL NAME: Evilyn Edwards

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex: 7 5. Color or race: W 6. (a) Single, widowed, married, divorced: m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

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

8. AGE: Years Months Days If less than one day
29 8 1 hr. min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace: (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace: (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof: (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)

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.

20. DATE OF DEATH: Month 4 day 28
year 1940 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: Presperal eclampsia
Died before physician arrived

Due to: 14b

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: # no abortion
Of operations: no delivery

Of autopsy _____

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? _____

While at work? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature: W. J. Huff (M. D. or other) _____
Address: _____ Date signed _____

SUPPLEMENTARY

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.