

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

15668

No. 2
 10-39
 1-17-39
 X21492

MAY 20 1947
 Registration District No. 4388

Primary Registration District No. 4388

State File No. _____
 Registrar's No. 38

1. PLACE OF DEATH:
 (a) County Pennington
 (b) City or town Caruthersville, mo
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 2
 (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) 21 2

3. (a) PRINT FULL NAME Sam H Edwards
 3. (b) If veteran, ✓ name war 2 3. (c) Social Security No. _____

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Edwards 6. (c) Age of husband or wife if alive 63 years
 7. Birth date of deceased Feb 21-1867
 (Month) (Day) (Year)

8. AGE: Years 71 Months 2 Days 1 If less than one day _____ hr. _____ min.

9. Birthplace Saline, Co, Ill
 (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business Stock Dealer
 { 12. Name Jack Edwards
 13. Birthplace West Tenn
 (City, town, or county) (State or foreign country)
 { 14. Maiden name Lizabath Mathison
 15. Birthplace West Tenn
 (City, town, or county) (State or foreign country)

16. (a) Informant S H Edwards
 (b) Address Caruthersville mo

17. (a) Burial (b) Date thereof 4-23-40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Little Prairie

18. (a) Signature of funeral director H J Smith
 (b) Address Caruthersville mo

19. (a) April 29, 1940 (b) Ada Martin
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State mo (b) County Pennington
 (c) City or town Caruthersville
 (If outside city or town limits, write "RURAL")
 (d) Street No. West 3rd
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ✓ _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 22 day apr
 year 1940 hour 1-30 minute 7 M.
 21. I hereby certify that I attended the deceased from Jan. 27, 1940 to April 22, 1940
 that I last saw him alive on April 21, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of mouth, throat and neck
 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? 585

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

23. Signature A. W. Chippel (M. D. or other) _____
 Address Caruthersville, Mo Date signed 4/30/40

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

MOTHER FATHER

5-40-16

45

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

Wall C. Deane

Licensed Embalmer No.

394

P. O. Address

Caruthersville

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. 10668
Registrar's No. 38

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 657

Primary Registration District No. 4388

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD.
ROWENA M...

1. PLACE OF DEATH:
(a) County Pemissot
(b) City or town Canthersville
(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 _____
In this community _____ (Specify whether
years, months or days)

3. (a) Sam H. Edwards
FULL NAME
(b) If veteran, name war _____
(c) Social Security No. _____

4. Sex M 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 71 Months 2 Days 1 If less than one day _____ 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)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) June 15, 1940 (b) Ada Martin
(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.

20. DATE OF DEATH: Month Apr day 22
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 Cancer of mouth
throat and neck

Due to Primary seat was
lower lip.

Due to _____

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

Major findings: 45
Of operations _____

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) _____ (c) Means of injury _____

23. Signature G. W. Phipps (M. D. or other) _____

Address Canthersville, Mo Date signed _____

SUPPLEMENTARY

PHYSICIAN
Underline the cause to which death should be charged statistically.

