

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. **24661**

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

Registration District No. **85**

Primary Registration District No. **1001**

Registrar's No. **786**

I. PLACE OF DEATH:

(a) County Buchanan
 (b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Joseph's Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 weeks
(Specify whether
 In this community 32 years
years, months or days)

8. (a) PRINT FULL NAME Nettie Edwards 363
 8. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married Married
 Charles Sr.
 6. (b) Name of husband or wife Charles Sr. 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased July 6, 1886
(Month) (Day) (Year)

8. AGE: Years 54 Months 0 Days 14 If less than one day
hr. min.

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

10. Usual occupation Housewife

11. Industry or business none

12. Name Henry Long
 13. Birthplace Virginia
(City, town, or county) (State or foreign country)

14. Maiden name Mary Cann
 15. Birthplace Harrison County, Mo.
(City, town or county) (State or foreign country)
Charles Edwards Sr.

16. (a) Informant 1515 Savannah Ave

(b) Address Burial (b) Date thereof July 23, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cem.

18. (a) Signature of funeral director Tracy Barry Funeral
218 South 10th St St. Joseph

(b) Address 7/23/40 (b) W. J. Nestles
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
St. Joseph
 (c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
 (d) Street No. 1515 Savannah Ave
(If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 20th
 year 1940 hour 6 minute _____ A.M.

21. I hereby certify that I attended the deceased from 6-24-40
 19____ to 7-20-40 19____
 that I last saw h.R.Y. alive on 7-19-40 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death cardiac failure

Due to auricular fibrillation

Due to Generalized edema

Other conditions 42 hr
(include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy none

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? 85 (Specify type of place)
 (a) Means of injury _____

23. Signature W. W. Stearns (M. D. or other) MD
 Address St. Joseph, Mo. Date signed July 22, 40

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

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

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 E. Myers

Licensed Embalmer No.

3220

P. O. Address

St. Joseph - 11

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.