

SEP 16 1940
Registration District No. 85

Primary Registration District No. 1001

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

1. PLACE OF DEATH:

(a) County Buchanan,
(b) City or town Saint Joseph,
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Missouri Methodist Hospital,
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 1 day
(Specify whether
In this community 3 months, 18 days,
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri, (b) County Buchanan
(c) City or town Rural,
(If outside city or town limits, write "RURAL")
(d) Street No. R.F.D. # 2, Wallace, Mo.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 4th.
year 1940 hour 7:00 minute 15 a. M.

21. I hereby certify that I attended the deceased from April 20, 1940, to August 4, 1940
that I last saw her alive on July 27, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Purpura with effusion; About streptococci
Duration 4 mos

Due to _____
Due to _____

Other conditions
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME Minnie Luella Edwards, 363

3. (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, divorced Married,

6. (b) Name of husband or wife Eugene Edwards, 6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased March 11, 1886,
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>54</u>	<u>4</u>	<u>23</u>	hr. _____ min.

9. Birthplace Unknown, North Carolina
(City, town, or county) (State or foreign country)

10. Usual occupation At Home,

11. Industry or business _____

MOTHER FATHER { 12. Name William N. Queen,
13. Birthplace Unknown, North Carolina
(City, town, or county) (State or foreign country)
14. Maiden name Mary Burnett,
15. Birthplace Unknown, North Carolina
(City, town, or county) (State or foreign country)

16. (a) Informant Eugene Edwards
(b) Address R.F.D. # 2, Wallace, Mo.

17. (a) Burial (b) Date thereof 8/6/40.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation Turner Cemetery,

18. (a) Signature of funeral director W. G. Beaman Funeral
(b) Address 319 S. 10th. Street, Hume

19. (a) Aug 7 1940 (b) A. J. Greutzbush
(Date received local registrar) (Registrar's signature)

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? _____

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

23. Signature W. G. Beaman (M. D. or other) _____
Address 3010 S. Blvd Date signed 8-6-40

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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 Aug 2-7

Registered Apprentice No.

working under my personal supervision.

Signed Wm. J. ...
Licensed Embalmer No. 15007

P. O. Address 319 South ...

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **27967**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **85**

Primary Registration District No. **1001**

Registrar's No. **854**

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

1. PLACE OF DEATH:

(a) County **Byzantium**
(b) City or town **St Joseph**
(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 **Minnie Louella 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 _____ years

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

8. AGE: Years **54** Months **4** Days **23** If less than one year _____ 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) **Oct 14, 1940** (b) **[Signature]**
(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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **4** 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: **Acute Pleurisy with effusion Streptococcus**

Due to: **Acute Bronchitis**

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

Major findings: Of operations **10th rib**
Of autopsy **[Signature]**

Duration _____
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. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTAL

→ 2.1.75