S. No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34340

FILED NOV 12 1940

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 3856

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: K.C.General Hospital No. 1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 days (Specify whether 30 Yrs

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City (If outside city or town limits write "RURAL")

(d) Street No. 3033 Wabash (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME ROHDA EDMONDSON

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex White

5. Color or race Female

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

6. (b) Name of husband or wife

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

7. Birth date of deceased January 16th. 1855 (Month) (Day) (Year)

8. AGE: Years 85 Months 8 Days 18 If less than one day hr. min.

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

10. Usual occupation At Home

11. Industry or business

FATHER
12. Name No Record Drake
13. Birthplace No Record (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name No Record
15. Birthplace No Record (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Bell Lane

(b) Address 3033 Wabash

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-6-1940 (Month) (Day) (Year)

(c) Place: burial or cremation Leeton, Missouri

18. (a) Signature of funeral director Mrs. C.L.Forster

(b) Address 918 Brooklyn Kansas City Mo.

19. (a) 10-5-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 4th year 1940 hour 3 minute 55 P. M.

21. I hereby certify that I attended the deceased from 9-27-40, 19, to 10-4-40, 19; that I last saw her alive on 10-4-40, 19; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Fracture of neck of right femur-accidental

Due to fall in home on 9-26-40

Due to

Other conditions Hypostatic bronchopneumonia (Include pregnancy within 3 months of death)

Major findings: Of operations 1 10

Of autopsy See above

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) Acc

(b) Date of occurrence Sept 26 1940

(c) Where did injury occur? K C Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)

While at work? (e) Means of injury Fall

23. Signature Emery R. Thom (M. D. or other)

Address Med. Dir. K.C.Gen.Hospital Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 Theron A. Redmon

Licensed Embalmer No. 8737

P. O. Address K.C. Mo.

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

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