S. No. 2
—1-4-41
. 5-17-39
PI X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILLED OCT 13 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 30526
Registrar's No. 3283

Registration District No. 399
Primary Registration District No. 1002

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: 4439 Woodland (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... In this community 45 yrs (Specify whether 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.: 4439 Woodland (If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No): O
If yes, name country .....

3. (a) PRINT FULL NAME: Ellsworth C. Edwards
3. (b) If veteran, name war: no
3. (c) Social Security No.: none
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Wid
6. (b) Name of husband or wife: Anna R. Edwards
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: Aug (Month) 2 (Day) 1863 (Year)

8. AGE: Years	Months	Days	If less than one day
78	0	7	..... hr. ..... min.

9. Birthplace: Mo. (City, town, or county) (State or foreign country)
10. Usual occupation: Carpenter
11. Industry or business .....
FATHER 12. Name: Tillman Edwards
FATHER 13. Birthplace: No Record (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Louise Stradman
MOTHER 15. Birthplace: W. Va. (City, town, or county) (State or foreign country)
16. (a) Informant: J. W. Edwards
(b) Address: 4439 Woodland
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 2 41 (Month) (Day) (Year)
(c) Place: burial or cremation: Memorial Park
18. (a) Signature of funeral director: Mrs C. L. Foster
(b) Address: 918 Brookline
19. (a) 9/2/41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 31 year 1941 hour 9 minute a M.
21. I hereby certify that I attended the deceased from Aug 28, 1941 to 8-31-, 1941 that I last saw him alive on 8-31-, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Acute Myocarditis	5 years
Due to: Arterial Sclerosis	2 years
Due to: Chronic Myocarditis	1 yr
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? ..... (Specify type of place)
While at work? ✓ (e) Means of injury: ✓
23. Signature: J. E. Everett (M. D. or other) D
Address: 1105 Grand Date signed: Sept 1941

(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.....

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, fact should be so stated above.