

FILED FEB 11 1942

Registration District No. 387

Primary Registration District No. 4227

Registrar's No.

1. PLACE OF DEATH:

(a) County. West Plains, Mo.
(b) City or town. West Plains, Mo.
(c) Name of hospital or institution: 1

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 3 yrs (Specify whether years, months or days)

In this community. 3 yrs

3. (a) PRINT FULL NAME Alis Frances Edwards

3. (b) If veteran. name war. ✓

3. (c) Social Security No. ✓

4. Sex 7 / 1 5. Color or race W 6. (a) Single, widowed, married. 2 divorced. W

6. (b) Name of husband or wife. Rufus Edwards 6. (c) Age of husband or wife if alive. ✓ years

7. Birth date of deceased. May 11 - 1883

8. AGE: Years 58 Months 6 Days 3 If less than one day hr. min.

9. Birthplace. Union Co., Mo., 1

10. Usual occupation. Housewife

11. Industry or business. ✓

12. Name. A. S. Wiley

13. Birthplace. Georgia

14. Maiden name. Margaret Peyton

15. Birthplace. Mo., 1

16. (a) Informant. Frank Edwards

(b) Address. West Plains, Mo.

17. (a) Removal (b) Date thereof. 11-16-41

(c) Place: burial or cremation. Wesley, Mo.

18. (a) Signature of funeral director. Wesley, Mo.

(b) Address. West Plains, Mo.

19. (a) 11-15-41 (b) Vida W. SIMONS

2. USUAL RESIDENCE OF DECEASED:

(a) State. Mo. (b) County. Harrow 46
(c) City or town. West Plains

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

(e) Citizen of foreign country? No (Yes or No)
If yes, name country. 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 14 P.
year 1941 hour 6 minutes 30 M.

21. I hereby certify that I attended the deceased from 4-22-1941 to 11-14-1941;
that I last saw h. a alive on 8-12-1941;
and that death occurred on the date and hour stated above.

Immediate cause of death. Carcinoma of Cervix
Carcinoma of Uterus

Due to.

Due to.

Other conditions. fda
(Include pregnancy within 3 months of death)

Major findings: 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) (e) Means of injury. 0

23. Signature E. B. Bohrer (M. D. or other) MD
Address West Plains, Mo. Date signed 11-15-41

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

344

RECEIVED

District Health Officer No. 8

District File Number 14244

Date Filed _____

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.....

.....
working under my personal supervision.

Registered Apprentice No. _____

Signed.....

[Handwritten Signature: D. A. Roberts]

Licensed Embalmer No. 3437

P. O. Address West Ham

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.