

No. 2  
9-4-41  
X29484

FILED FEB 16 1942  
Registration District No. 394

Primary Registration District No. 5703

Registrar's No. 33

1. PLACE OF DEATH:

(a) County Macon

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

(c) Name of hospital or institution: 4

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

(d) Length of stay: In hospital or institution 72 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon 61

(c) City or town Bevier (If outside city or town limits, write "RURAL") RURAL 0

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

(e) Citizen of foreign country? - (Yes or No)

If yes, name country -

3. (a) PRINT FULL NAME ANN EDWARDS

3. (b) If veteran, name war -

3. (c) Social Security No. -

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUN day 28 year 1942 hour 3 minute 30 P M.

4. Sex FEMALE 5. Color or race White

6. (a) Name of husband or wife DANIEL T. EDWARDS 6. (b) Single, widowed, married, divorced, widowed

7. Birth date of deceased: OCTOBER 10 1858 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1937 to Jan 23, 1942 that I last saw her alive on Jan 23, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death: Pneumonia Duration 4 days

8. AGE: Years 83 Months 3 Days 13 If less than one day hr. min.

Due to .....

Due to .....

9. Birthplace: South Wales (City, town, or county) (State or foreign country)

Other conditions: Cardiovascular disease (Include pregnancy within 3 months of death)

10. Usual occupation: Domestic

11. Industry or business: .....

12. Name: DAVID J. EVANS

13. Birthplace: South Wales (City, town, or county) (State or foreign country)

14. Maiden name: MARY LLOYD

15. Birthplace: South Wales (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Edwards

(b) Address: Bevier, Mo

17. (a) Burial (b) Date thereof: 1-25-42 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: East Overwood

18. (a) Signature of funeral director: W. H. Gilliland

(b) Address: New Canaan, Mo

19. (a) (Date received local registrar) (b) (Registrar's signature)

Major findings: Of operations: .....

Of autopsy: 107

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? .....

23. Signature: W. H. Gilliland (Specify type of place) (c) Means of injury: .....

Address: Macon MO Date signed: 2-2-42

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

106

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 2-42-265

Date Filed FEB 12 1942

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

*H. J. Gilleland*

Licensed Embalmer No. 4019

P. O. Address New Cambria, Mo.

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. 2791

Registration District No. 521

Primary Registration District No. 5703

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH: Macon  
 (a) County Bevier  
 (b) City or town \_\_\_\_\_  
 (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 Ann Edwards  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced w  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Oct. (Month) 0 (Day) 1900 (Year)

8. AGE: Years 83 Months 3 Days \_\_\_\_\_ (If less than one day \_\_\_\_\_ min.)

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 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) 2/4/42 (Date received local registrar) (b) Mrs. Tom Butt (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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Jan day \_\_\_\_\_ year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_  
 that I last saw him \_\_\_\_\_ live on \_\_\_\_\_ 19\_\_\_\_  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (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 \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

