

FILED MAY 6 1942

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 St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1418 South 13th / none  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 months - 2 weeks (Specify whether none)

In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan / /

(c) City or town St. Joseph /  
(If outside city or town limits, write "RURAL")

(d) Street No. 1418 South 13th  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 1

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Nea June Edwards

3. (b) If veteran, name war none

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 27th  
year 1942 hour 1 minute A.M.

21. I hereby certify that I attended the deceased from 4-26-42  
19 4-26-42 19 4-26-42

that I last saw her alive on 4-26-42 19 4-26-42  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color of race white

6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: February 9, 1942  
(Month) (Day) (Year)

Immediate cause of death Circulatory Failure Duration From history 48 hrs

Due to Internal Hemorrhage

Due to Intestinal Obstruction

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years 0 Months 2 Days 18 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace St. Joseph, Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation child

Major findings: Of operations none

Of autopsy no

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

12. Name Higbee Edwards

13. Birthplace Wallace, Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Helen Gust

15. Birthplace St. Joseph, Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Higbee Edwards

(b) Address 1418 South 13th

17. (a) Burial (b) Date thereof 4-29, 1942  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Auburn Cemetery

18. (a) Signature of general director Tracy Barry Funeral

(b) Address 218 South 10th St

19. (a) 4-29-42 (b) Rae Herzog  
(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? Home  
(Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury ✓

23. Signature E. L. Ferguson (M. D. or other) BD  
Address 801 1/2 Franklin St Date signed 4-27-42

**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.....

*Victor J. Barry*

Licensed Embalmer No. ....

*4212*

P. O. Address.....

*St Joseph 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. 13791

Registration District No. ....

Primary Registration District No. 1001

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Buchanan  
(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 Nea June 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.....

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 Months Days (If less than one day min.)

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

10. Usual occupation

11. Industry of 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Buchanan  
(c) City or town St Joseph  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1418 South 13th  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr Day 27 Year 1949 Hour 1 minute 2 A.M.

21. I hereby certify that I attended the deceased from..... 19.....  
that I am a physician who has lived on..... 19.....  
and that death occurred on the date and hour stated above.

Immediate cause of death Circulatory system failure  
Internal hemorrhage  
Due to Intestinal obstruction

Due to It is my opinion that the Intestinal obstruction  
Other conditions was probably due to a malignant condition

Major findings: Of operations Cancer

Of autopsy H6

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.....

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

