

FILED OCT 10 1942

Registration District No. **49**

Primary Registration District No. **5175**

Registrar's No. **16**

15
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH
 (a) County **Camden**
 (b) City or town **Russell Road Rural**
(If outside city or town limits, write "RURAL" and name of township)
 (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 _____
(Specify whether years, months or days)
 In this community **52 years**

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Camden**
 (c) City or town **Road (Rural)**
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **ELNORA F. EDSON**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **Sept** day **26**
 year **1942** hour **1** minute **50 P.M.**

4. Sex **F** 1 5. Color or race **White**
 6. (a) Single, widowed, married, divorced, **married**
 6. (b) Name of husband or wife **Herman Edson**
 6. (c) Age of husband or wife if alive **52** years
 7. Birth date of deceased **Sept 22 - 1890**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Sept 1, 1941**, 19 to **Sept 26, 1942**
 that I last saw her alive on **Sept 26, 1942**
 and that death occurred on the date and hour stated above.

8. AGE: Years **52** Months **4** Days _____ If less than one day _____ hr. _____ min.

Immediate cause of death: **Myocardial Insufficiency of heart - Chronic**
 Due to _____
 Due to _____

9. Birthplace **Camden Co Mo**
(City, town, or county) (State or foreign country)

Other conditions **Uterus removed**
(Include pregnancy within 8 months of death)
 Duration **41**
 Duration **42**

10. Usual occupation **Housewife**

11. Industry or business _____
 12. Name **James W. Laughlin**
 13. Birthplace **Leann 1**
(City, town, or county) (State or foreign country)
 14. Maiden name **Rebecca Morgan**
 15. Birthplace **Dayton Ohio**
(City, town, or county) (State or foreign country)

PHYSICIAN
 Major findings: _____
 Of operations _____
 Of autopsy **none**
 Underline the cause to which death should be charged statistically.

16. (a) Informant **Herman Edson**
 (b) Address **Road**
 17. (a) **Buried** (b) Date thereof **Sept 27-42**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Praine Hobbs**

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? _____

18. (a) Signature of funeral director **B. J. Jones**
 (b) Address **2330 Russell Rd**
 19. (a) **9-29-42** (b) **Mrs. G. R. Jackson**
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) _____
 (e) Means of injury _____
 23. Signature **E. J. C. Lee** M. D. of other _____
 Address **Camden, Mo.** Date signed **9-29-42**

101.2
2-8-7
S.A. 1.1

RECEIVED

District Health Officer No. 7;

District File Number 10-42-1048

Date Filed 10-3-42

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 Leonard B Jones

Licensed Embalmer No. 2508

P. O. Address Buffalo, N.Y.

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. 30001

Registration District No. 49

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County Camden
(b) City or town Rural
(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)

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 _____

3. (a) PRINT FULL NAME Elvora F. Edson

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 M

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

7. Birth date of deceased Sept 22
(Month) (Day) (Year)

8. AGE: Years 52 Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Day 22 Year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death myocardial insufficiency of heart checked Duration 1 1/2

Due to _____

Due to _____

Other conditions Gall Bladder removed #2
(Include pregnancy within 3 months of death)

Major findings: Non-malignant
Of operations _____

Of autopsy 92 f

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER, FATHER

