

JUN 24 1943

Registration District No. 156

Primary Registration District No. 2001

Registrar's No. 320

1. PLACE OF DEATH

(a) County Jasper
(b) City or town Joplin
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Johns Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days
(Specify whether years, months or days)

In this community _____ years, months or days

3. (a) PRINT FULL NAME Marie Helia Edens

3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex F 5. Color or race white 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife T. C. Edens 6. (c) Age of husband or wife if alive 37 years

7. Birth date of deceased Feb 18 1907
(Month) (Day) (Year)

8. AGE: Years 35 Months 4 Days If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name A. B. Glasgow

13. Birthplace unknown Virginia
(City, town, or county) (State or foreign country)

14. Maiden name Katherine Phillips

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

16. (a) Informant T. C. Edens

(b) Address 506 E 15th

17. (a) Funeral (b) Date thereof June 4 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbus, Kan.

18. (a) Signature of funeral director Walter Jostus

(b) Address Byler Springs, Kan.

19. (a) 6-11-43 (b) Walter Jostus
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Chester
(c) City or town Byler Springs
(If outside city or town limits, write "RURAL")
(d) Street No. 15th Washington
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 2 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 4th year 1943 hour 4:45 minute A M.

21. I hereby certify that I attended the deceased from July 1932 to June 4 1943
that I last saw her alive on June 4 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Embolism
Due to Postoperative (double salpingectomy)
Duration 1 1/2 hrs
48 hrs

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? _____

While at work? (Specify type of place) (e) Means of injury _____

23. Signature Walter Jostus (M. D. or other) MD
Address Byler, Mo Date signed 6-7-43

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

43-6-605

1.22
-750
1.14

25

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 Walter Haskins

Licensed Embalmer No. 784

P. O. Address Bayton Springs, Miss

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, above space should be left blank.

Registration District No. 156

Primary Registration District No. 2001

Registrar's No. 321

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

1. PLACE OF DEATH:
 (a) County Jasper
 (b) City or town Joplin
(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 Marie Lelia Edema
 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 Feb 1 1900
(Month) (Day) (Year)
 8. AGE: Years 35 Months _____ Days _____ If less than one day _____ min.

9. Birthplace Kansas
(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 _____
(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)

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 January year 1943 day _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Embolism Duration _____
 Due to Post operation (double surgery)
(Ch. Atrophy)
 Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
 Of operations 139a
 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 _____ (M. D. or other) _____
 Address _____ Date signed _____

S-21613