V. S. No. 2
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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 20 1944

Registration District No. 34

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5208

State File No. 24361

Registrar's No. 14

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

17
0
0

1. PLACE OF DEATH:

(a) County Carroll Hurricane

(b) City or town Hale Missouri R.F.D. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Home S.E. Bale (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 Missouri (b) County Carroll 17

(c) City or town Hale Missouri R.F.D. (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 Donna Rae 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 ~~[illegible]~~ child

6. (b) Name of husband or wife James C Edwards

6. (c) Age of husband or wife if alive — years

7. Birth date of deceased June (Month) 1st (Day) 1944 (Year)

8. AGE: Years 0 Months 0 Days 1 If less than one day hr. min.

9. Birthplace Hale Missouri R.F.D. (City, town, or county) (State or foreign country)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name James C. Edwards
13. Birthplace Koshkong Missouri (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Minnie Margaret Frost
15. Birthplace Gallatin Missouri (City, town, or county) (State or foreign country)

16. (a) Informant James C Edwards

(b) Address Hale Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/2/1944 (Month) (Day) (Year)

(c) Place: burial or cremation Hurricane

18. (a) Signature of funeral director Clifford W. Austin

(b) Address Tina Missouri

19. (a) 6-3-44 (Date received local registrar) (b) Mrs Edgar Smith (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 1st. year 1944 hour 4 minute 50 P.M.

21. I hereby certify that I attended the deceased from Birth at 4:30 - 6-1, 1944, to 6-1, 1944; that I last saw her alive on 6-1-, 1944; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Asphyxia	20 min
Due to Mucus & fluid in Bronchial tree	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

16 a

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature R. W. Mathiny (M. D. or other) DO

Address Tina, Mo Date signed 6-2-44

(Licensed Embalmer's Statement on Reverse Side)

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 Body Was Not Embalmed., Registered Apprentice No. 3233, working under my personal supervision.

Signed Clifford W Austin

Licensed Embalmer No. 3233

P. O. Address Tina, Missouri

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.