

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37122

State File No. _____

Registrar's No. 70

FILED NOV 22 1944

Registration District No. 22

Primary Registration District No. 5117

1. PLACE OF DEATH:
Boone
 (a) County Boone
 (b) City or town in Cedar T S
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: XX
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1
(Specify whether
 In this community life
years, months or days)

3. (a) PRINT FULL NAME WILLIAM EZRA EDWARDS
 3. (b) If veteran, name war XX
 3. (c) Social Security No. XX

4. Sex M 0 5. Color or race W
 6. (a) Single, widowed, married, divorced U S
 6. (b) Name of husband or wife XX
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased FEBY 25th 1872
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
72 6 23 hr. _____ min.

9. Birthplace BOONE CO MISSOURI
(City, town, or county) (State or foreign country)
 10. Usual occupation FARMER

MOTHER { 11. Industry or business _____
 FATHER { 12. Name WINFIELD SCOTT EDWARDS
 13. Birthplace VIRGINIA
(City, town, or county) (State or foreign country)
 14. Maiden name SALLIE ADELINE TELFORD
 15. Birthplace MISSOURI
(City, town, or county) (State or foreign country)

16. (a) Informant J.G. EDWARDS
 (b) Address COLUMBIA

17. (a) BURIAL (b) Date thereof SEPT 21-44
(Burial, cremation, or removal) (Month) (Day) (Year)
NASHVILLE CEM

18. (a) Signature of funeral director [Signature]
 (b) Address COLUMBIA MO

19. (a) 11-7-44 (b) Mrs. Abby Estis
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State MISSOURI (b) County BOONE 10
 (c) City or town CEDAR T.S. 0
(If outside city or town limits, write "RURAL")
 (d) Street No. XX 0
(If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country XX

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month SEPT day 18th
 year 1944 hour 8:20 minute P M.

21. I hereby certify that I attended the deceased from Mar
1 1944 to Sept 18 1944
 that I last saw him alive on Sept 18 44
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral of free
 Due to _____

Due to 53
 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 [Signature] (M. D. or other) _____
 Address [Signature] Date signed 9-20-44

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

RECEIVED

District Health Officer No. 9

District File Number _____

Date Filed _____

11-18-44

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 _____

Licensed Embalmer No. _____

P. O. Address _____

Rowley
3183
Columbia

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.