

FILED FEB 15 1945

Registration District No. 1

Primary Registration District No. 2007

Registrar's No. 9

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

1. PLACE OF DEATH:
 (a) County BUTLER
 (b) City or town POPLAR BLUFF
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
POPLAR BLUFF HOSPITAL
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 6 DAYS
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State MO (b) County BUTLER
 (c) City or town RURAL Williamsville
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? 1 (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME ROTH MAY EDWARDS
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Jan day 11, year 1945 hour 7 minute 15 P. M.
 21. I hereby certify that I attended the deceased from 1-5, 1945, to 1-11, 1945; that I last saw her alive on 1-11, 1945; and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced SINGLE
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

Immediate cause of death Cardiac failure
Patent Foramen Ovale
 Due to _____
 Due to _____
 Duration 6 days

7. Birth date of deceased JAN 5 1945
(Month) (Day) (Year)
 8. AGE: Years _____ Months _____ Days 6 If less than one day _____ hr. _____ min.

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

Other conditions None
(Include pregnancy within 3 months of death)
 Major findings: Of operations _____
 Of autopsy _____

10. Usual occupation _____
 11. Industry or business _____

MOTHER FATHER
 12. Name WALTER EDWARDS
 13. Birthplace HONDRICKSON MO
(City, town, or county) (State or foreign country)
 14. Maiden name FDA MARIL ALEXANDER
 15. Birthplace HENDRICKSON MO
(City, town, or county) (State or foreign country)

PHYSICIAN
 Underline the cause to which death should be charged statistically.
None

16. (a) Informant Walter Edwards
 (b) Address RFD #2 Williamsville Mo
 17. (a) BURIAL (b) Date thereof JAN 12 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation MT ZION CEMETERY

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 None

18. (a) Signature of funeral director W. J. Phelps
 (b) Address Poplar Bluff Mo
 19. (a) 1-13-45 (b) Bruce Turner
(Date received local registrar) (Registrar's signature)

23. Signature J. W. Tronda (M. D. or other) 1/11/45
 Address Poplar Bluff, Mo Date signed 1/11/45

RECEIVED
RECEIVED
District Health Office No. 2,
District File Number 245-178
Date Filed
Date Filed Number
Date Filed 2-7-45

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 ^{NOT}.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed *N. T. P. [Signature]*
Licensed Embalmer No. 3231
P. O. Address *Caplan Bluff 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.