. No. 2
I—5-43
5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 28144

FILED SEP 13 1945

Registration District No. 30 52 Primary Registration District No. Registrar's No. 217

1. PLACE OF DEATH:

(a) County: PETTIS

(b) City or town: SEDALIA
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: BOTHWELL HOSPITAL 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 1-WEEK (Specify whether years, months or days)

In this community: 1-WEEK

2. USUAL RESIDENCE OF DECEASED:

(a) State: MISSOURI (b) County: BENTON 8

(c) City or town: WARSAW (RURAL) 0
(If outside city or town limits, write "RURAL")

(d) Street No.: R.F.D. #3 0
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 1

If yes, name country

3. (a) PRINT FULL NAME: ELBERT R. EDWARDS

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

4. Sex: MALE ♂ 5. Color or race: WHITE 6. (a) Single, widowed, married, divorced: MARRIED

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

7. Birth date of deceased: 12 (Month) — 2 (Day) — 1885 (Year)

8. AGE: Years 59 Months 8 Days 17 If less than one day hr. min.

9. Birthplace: NOBY (City, town, or county) MO. 0 (State or foreign country)

10. Usual occupation: FARMER

11. Industry or business:

FATHER
12. Name: HENRY EDWARDS
13. Birthplace: NOBY (City, town, or county) MO 0 (State or foreign country)

MOTHER
14. Maiden name: VIRGINIA CRANE
15. Birthplace: — (City, town, or county) MO. 0 (State or foreign country)

16. (a) Informant: MRS E. R. EDWARDS
(b) Address: RTE 3 - WARSAW

17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof: 8-19-1945 (Month) (Day) (Year)
(c) Place: burial or cremation: WARSAW, MO.

18. (a) Signature of funeral director: Gillespie
(b) Address: SEDALIA MO.

19. (a) 8/19/45 (Date received local registrar) (b) Mrs Quinn Berger (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 19 year 1945 hour 5:45 minute P M.

21. I hereby certify that I ~~attended~~ visited the deceased from Aug 19 1945 to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

Immediate cause of death: Fracture of right Parietal Bone of Skull — Duration

Due to: a Fall Down steps at The Hospital

Due to:

Other conditions: Typhoid Fever — 1 week
(Include pregnancy within 3 months of death)

Major findings:
Of operations: 1
Of autopsy: 166 W 3d 2 U.

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 80

(a) Accident, suicide, or homicide (specify):

(b) Date of occurrence:

(c) Where did injury occur? Sedalia (City or town) Pettis (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Bothwell Hospital (Specify type of place)

While at work? (e) Means of injury: Fall Down stairs

23. Signature: Dr. H. L. Waldman 3 (M. D. or other) M.D. Coroner

Address: 329 Ellsworth Bldg. Date signed: 8/19/45

1022 (Licensed Embalmer's Statement on Reverse Side) Sedalia, Mo.

SEP 26 1945

RECEIVED
District Health Officer No. 8,
District File Number.....
Date Filed 9-12-45

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Geo. Dillard

Licensed Embalmer No. 3868

P. O. Address Dublin

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.

No. 2B
—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 28144

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 217

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Pettis

(b) City or town Sedalia
(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 Elbert R. Edwards

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

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 Dec (Month) 2 (Day) 1880 (Year)

8. AGE: Years 59 Months 8 Days 17 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 19
year 1945 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
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 1 Aug 1945

(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 Dr. K. L. Holden coroner (M. D. or other) D.O.
Address 329 Elgin Bldg Sedalia, Mo. Date signed 10/19/45

JUN 26 1945

1945

S-28144