

No. 2  
-8-43  
5-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 11

Registration District No. 9176  
**FILED JAN 5 1946**

1. PLACE OF DEATH:  
(a) County Dunklin  
(b) City or town Malden  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
407 S. Decatur  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution no (Specify whether)  
In this community 45 years  
years, months or days

3. (a) PRINT FULL NAME Mrs. Wade Edmundson  
3. (b) If veteran, name war no  
3. (c) Social Security No. no

4. Sex female  
5. Color or race white  
6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife E. E. Edmundson  
6. (c) Age of husband or wife if alive de. years  
7. Birth date of deceased March 9 1864  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
81 9 4 -- hr. -- min.

9. Birthplace Gibson Co. Tenn.  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Housewife  
11. Industry or business none

MOTHER FATHER { 12. Name Chesley Adams  
13. Birthplace Gibson Co. Tenn.  
(City, town, or county) (State or foreign country)  
14. Maiden name Nancy E. Oliver  
15. Birthplace Gibson Co. Tenn.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. W. E. Mooney  
(b) Address Malden, Mo.

17. (a) Burial (b) Date thereof 12-16-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Malden Memorial Park

18. (a) Signature of funeral director Day Funeral Home  
(b) Address Malden, Missouri

19. (a) 12-22-45 (b) J. S. Schuman  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Dunklin 35  
(c) City or town Malden 2  
(If outside city or town limits, write "RURAL")  
(d) Street No. 407 S. Decatur 1  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Dec. day 13  
year 1945 hour 10 minute 50 P.M.

21. I hereby certify that I attended the deceased from July 5 1944 to Dec 13 1945  
What I last saw her alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial infarction  
Due to arterial changes and age  
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 \_\_\_\_\_  
(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) \_\_\_\_\_ (Specify type of place)  
Means of injury \_\_\_\_\_  
23. Signature J. C. Carlton (M.D. or other) DO  
Address Malden Date signed Dec 14/45

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

RECEIVED

District Health Office No. 2,

District File Number 146-342

Date Filed 1-2-46

**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.....

*J. E. Johnson*

Licensed Embalmer No. 4086

P. O. Address Malden, 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. ....

104

Primary Registration District No. ....

4176

Registrar's No. ....

11

1. PLACE OF DEATH

- (a) County Franklin
- (b) City or town Malden  
(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

Mrs Wade Edmondson

- 3. (b) If veteran, name war no

- 3. (c) Social Security No. no

- 4. Sex F
- 5. Color or race w
- 6. (a) Single, widowed, married, divorced wid

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

- 7. Birth date of deceased Mar 9 1886  
(Month) (Day) (Year)

- 8. AGE: Years 81 Months Days If less than one day  
hr. min.

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

- 10. Usual occupation

- 11. Industry or business

- 12. Name
- 13. Birthplace (City, town, or county) (State or foreign country)
- 14. Maiden name (State or foreign country)
- 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)

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 Dec Day 3  
year 1945 hour..... minute..... M.

- 21. I hereby certify that I attended the deceased from..... 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 Chronic nephritis

Due to Part of Sexual heading of arterial tumor.

Other conditions..... (Include pregnancy within 3 months of death)

Major findings: ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
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 J. Carleton (M. D. or other).....  
Address..... Date signed.....

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

SUPPLEMENTARY

41088