

FILED JUN 20 1946  
Registration District No. 347

Primary Registration District No. 4508

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

1. PLACE OF DEATH:

(a) County Stanly Salera

(b) City or town Salera  
(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 and local address)

(d) Length of stay: In hospital or institution about 2 weeks (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stone 104

(c) City or town Salera (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 Claborn Edwards

3. (b) If veteran, name war no

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 19 year 1946 hour 4 minute 30 P.M.

21. I hereby certify that I attended the deceased from at Death May 19, 1946, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him on May 19, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia

Duration 2 Days

4. Sex ma 5. Color or race wh

6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased: Oct 24 1874  
(Month) (Day) (Year)

Due to Lack of medical care

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

8. AGE: Years 71 Months 6 Days 25 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Cape Fair Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business \_\_\_\_\_

12. Name Marion Edwards

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

14. Maiden name Marry E

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. W. O. Jackson - Social Sec.

(b) Address Salera Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 20-46 (Month) (Day) (Year)

(c) Place: burial or cremation Blenning Cemetery

18. (a) Signature of funeral director Evelyn J. Cheatham

(b) Address Salera, Mo

19. (a) May 25-46 (Date received local registrar) (b) Lena Murray - Dep. (Registrar's signature)

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 3

23. Signature Evelyn J. Cheatham (Doctor or other) Coroner

Address Salera Mo Date signed 5-20-46

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

WRITE PLAINLY - USE UNWRITING BLACK INK - MAKE A PERMANENT RECORD

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 *Everett J. Cheatham*

Licensed Embalmer No. *3876*

P. O. Address *Galena 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. July  
Registrar's No. \_\_\_\_\_

Registration District No. 347 Primary Registration District No. 4508

1. PLACE OF DEATH:  
(a) County Stone  
(b) City or town Galena  
(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 Claborn 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 wid  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Oct 24 (Month) (Day) (Year)

8. AGE: Years 71 Months 9 Day \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. mo

9. Birthplace \_\_\_\_\_ (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 \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

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

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (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 \_\_\_\_\_

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_ Year 1946 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.

Duration \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions Mental Depression Condition  
(Include pregnancy within 3 months of death)

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
Major findings: Of operations No operations  
Of autopsy none

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) (c) Means of injury \_\_\_\_\_  
23. Signature Everett J. Heath (M.D. or other) carver  
Address Galena mo Date signed 5/12/46

SUPPLEMENTARY

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

21324

22457