

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STANDARD CERTIFICATE OF DEATH

State File No. **26136**

Registration District No. **1**

Primary Registration District No. **3000**

Registrar's No. **222**

1. PLACE OF DEATH:

(a) County **ADAIR**
(b) City or town **IRKSVILLE**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
ASO
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **30 DAYS**
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **SULLIVAN** ¹⁰⁵
(c) City or town **MILAN** ¹
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) ⁰
(e) Citizen of foreign country? _____ (Yes or No) ¹
If yes, name country _____

3. (a) PRINT FULL NAME **MARGARET ANN EDWARDS**

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

4. Sex **FE** / 5. Color or race **W** 6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **LEE EDWARDS** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **MAR 20 1885**
(Month) (Day) (Year)

8. AGE: Years **61** Months **4** Days **15** If less than one day hr. _____ min. _____

9. Birthplace **MILAN MO**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSEWIFE**

11. Industry or business _____

12. Name **MATHEW MCCRACKIN**

13. Birthplace **Irksville MO**
(City, town, or county) (State or foreign country)

14. Maiden name **MARY CALDWELL**

15. Birthplace **MILAN MO**
(City, town, or county) (State or foreign country)

16. (a) Informant **LEE EDWARDS**
(b) Address **MILAN MO**

17. (a) **BURIAL** (b) Date thereof **AUG 7 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **SHATIO**

18. (a) Signature of funeral director **James & Son**

(b) Address **Milans Mo**

19. (a) **8-6-46** (b) **Kate Lambert**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **AUG** day **5**
year **1946** hour **5:00** minute _____ P. M.

21. I hereby certify that I attended the deceased from **July 11**, 19**46** to **Aug 5**, 19**46**
that I last saw him alive on **Aug 4**, 19**46**; and that death occurred on the date and hour stated above.

Immediate cause of death **Lobar Pneumonia** <sup>Dysphagia
E ^{always}</sup>

Due to **Diabetes mellitus** ^{30 yrs.}

Due to _____

Other conditions **Amputation Right leg July 16 1946**
(Include pregnancy within 3 months of death)

Major findings: **above knee**
Of operations: **Gangrene R. foot**

Of autopsy **61**

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) Means of injury _____

23. Signature **K. J. Foster** (M. D. or other) ²

Address **Irksville Mo** Date signed **8/6/46**

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

RECEIVED
District Health Officer No. 10
District File Number 8-46-1544
Date Filed AUG 14 1946

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 James O. Riggs

Licensed Embalmer No. 3792

P. O. Address Mpls. 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.