

S. No. 2  
M-2-43  
5-17-39  
X35697

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

5299

FILED FEB 20 1947

State File No. \_\_\_\_\_

Registration District No. 169

Primary Registration District No. 4258

Registrar's No. 97

1. PLACE OF DEATH:

(a) County Knox

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

(c) Name of hospital or institution: Gibson Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Knox 5-2

(c) City or town Edina  
(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 Bobby Gene Small

MEDICAL CERTIFICATION

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

20. DATE OF DEATH: Month Feb-8- day \_\_\_\_\_ year 1947 hour 11 minute 02 A M.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced 0

21. I hereby certify that I attended the deceased from Feb 5, 1947, to Feb 9, 1947; that I last saw him alive on Feb 8, 1947; and that death occurred on the date and hour stated above.

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

Immediate cause of death: Erythroretroia Fatalis Duration 3 days

7. Birth date of deceased: Feb-5 - 1947  
(Month) (Day) (Year)

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

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 4 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

9. Birthplace: Edina Missouri  
(City, town, or county) (State or foreign country)

Major findings: 161C  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

10. Usual occupation \_\_\_\_\_

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

12. Name Tommy Small

13. Birthplace: Creston Iowa  
(City, town, or county) (State or foreign country)

14. Maiden name Doris Irene Parrish

15. Birthplace: Edina Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Tommy Small  
(b) Address Edina, Mo.

17. (a) Burial (b) Date thereof Feb-9-1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Linville, Edina, Mo.

18. (a) Signature of funeral director Keith Hudson  
(b) Address Edina, Mo.

19. (a) Feb-10-47 (b) Thelle S. Nunn  
(Date received local registrar) (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 0

23. Signature C. C. Gibson (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed 2/8/47

151 (Licensed Embalmer's Statement on Reverse Side)

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

2  
10

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**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 Keith Hudson  
Licensed Embalmer No. 2415  
P. O. Address Edina, Minn.

**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.**