DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 6 1947

Registration District No. 239

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 18217

Primary Registration District No. 5825

Registrar's No. 100

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town Lilbourn Rt. 1 (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: None (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None (Specify whether

In this community 1 Year years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid

(c) City or town Lilbourn Rt I 72 (If outside city or town limits, write "RURAL")

(d) Street No On Catron Ditch South of Highway 62 (If rural, give location)

(e) If foreign born, how long in U. S. A.? No years.

3. (a) PRINT FULL NAME Icy Beatrice Edwards

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex F 3

5. Color or race Negro

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

6. (b) Name of husband or wife W. H. Edwards

6. (c) Age of husband or wife if alive 26 years

7. Birth date of deceased Dec. (Month) 26 (Day) 1921 (Year)

8. AGE: Years 25 Months 4 Days 0 If less than one day ___ hr. ___ min.

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

10. Usual occupation Housewife

11. Industry or business

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

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

16. (a) Informant's own signature W. H. Edwards

(b) Address Lilbourn Rt I

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 4-47 (Month) (Day) (Year)

(c) Place: burial ~~or cremation~~ Ditch 8 Cemetery

18. (a) Signature of funeral director Watkins Funeral Service

(b) Address Parma Mo

19. (a) 6/6/47 (Date received local registrar) (b) Dr Geo W Husted (Registrar's signature) 217

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 26 year 1947 hour 6 minute 00 A M.

21. I hereby certify that I attended the deceased from April 25, 1947, to April 26, 1947; that I last saw her alive on April 25, 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Apoplexy	
Due to Hemorrage Cerebral	
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Edward M. Popp (M. D. or ~~other~~)

Address Marston Mo Date signed 5-8-47

(Licensed Embalmer's Statement on Reverse Side)

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED
District Health Office No. 2
District File Number
Date Filed

RECEIVED
District Health Office No. 2,
District File Number 647-816
Date Filed 6-5-47

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 Lyman Steele

Licensed Embalmer No. 2476

P. O. Address Dexter 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, above space should be left blank.