

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

34286

State File No.

Registrar's No.

Filed OCT 23 1947
Registration District No.

Primary Registration District No. 5512

1. PLACE OF DEATH:

(a) County Henry
(b) City or town Honey Creek Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
On Highway 35 1/2 miles no
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 (Specify whether
In this community 5 years, months or days)

3. (a) PRINT FULL NAME EDWIN ALBERT FLOYD

3. (b) If veteran, name war 20 war 2 3. (c) Social Security No.

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive 7 years (Month) (Day) (Year)
7. Birth date of deceased March 7 1924

8. AGE: Years Months Days If less than one day
21 7 10 .hr. min.

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

10. Usual occupation Mechanic

11. Industry or business

12. Name Gustave H Floyd

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

14. Maiden name Marion B. Lindsey

15. Birthplace Marionville Mo (City, town, or county) (State or foreign country)

16. (a) Informant Robert S Floyd

(b) Address Ascola Mo

17. (a) Burial (b) Date thereof 10-30-47 (Month) (Day) (Year)

(c) Place: burial or cremation Ascola Mo

18. (a) Signature of funeral director F B Hoodrich

(b) Address Ascola Mo

19. (a) 10-18-47 (b) R R Ramsey (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson 48
(c) City or town Kansas City Mo 3
(If outside city or town limits, write "RURAL")
(d) Street No. 2731 Kensington 8
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No) 1
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 17
year 1947 hour 7 minute 30 P M

21. I hereby certify that I attended the deceased from 10 days or more to 19 that I last saw the deceased on 19 and that death occurred on the date and hour stated above.

Immediate cause of death Fractured skull caused by an auto accident

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 170 cc of blood

Of autopsy 8

PHYSICIAN'S

Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident 42

(b) Date of occurrence Oct 17 1947

(c) Where did injury occur? Truck Henry Twp (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 1/4 mi east of Truck Twp on Hwy 35 (Specify type of place)

While at work? yes (a) Means of injury Car 3

23. Signature Dr. P. S. Tatum Date signed 10/18/47

Address Clinton Twp

RECEIVED
District Health Officer No. 7,
District File Number 9-47-1225
Date Filed 10-20-47
6 days 1019

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

R R Kenney

Licensed Embalmer No.

3099

P. O. Address

Clinton 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.