

FILED OCT 1 1948

Registration District No. **73**

Primary Registration District No. **6291**

Registrar's No. **79**

1. PLACE OF DEATH:

(a) County **Clay**
(b) City or town **Rural- Near Chandler Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Clay Co. Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **10 days** (Specify whether
In this community **unknown**
years, months or days)

3: (a) PRINT FULL NAME **EDWARD ERSKINE**

3: (b) If veteran, name war **not known** 3: (c) Social Security No. **no**

4. Sex **Male** 5. Color or race **W**
6: (a) Single, widowed, married, divorced **##9**
6: (b) Name of husband or wife **#####** 6: (c) Age of husband or wife if alive **1867** years
7. Birth date of deceased **About** (Month) (Day) (Year)

8. AGE: Years **80** Months Days If less than one day hr. min.

9. Birthplace **Tilden** **Nebr** (City, town, or county) (State or foreign country)

10. Usual occupation **unknown**

11. Industry or business

MOTHER FATHER { 12. Name **unknown**
13. Birthplace **unknown** (City, town, or county) (State or foreign country)
14. Maiden name **unknown**
15. Birthplace **unknown** (City, town, or county) (State or foreign country)

16: (a) Informant **Clay Co. Home records**
(b) Address **Liberty Missouri**
17: (a) **burial** (b) Date thereof **9-14-48** (Month) (Day) (Year)
(c) Place: burial or cremation **Clay Co Home - Cemetery**
18: (a) Signature of funeral director **Chas O. Hoga**
(b) Address **Excelsior Springs Mo**
19: (a) **9-14-1948** (b) **Minnie Hays** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Clay**
(c) City or town **Excelsior Springs**
(If outside city or town limits, write "RURAL")
(d) Street No. **103 South Street.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **9-12** day **11** year **1948** hour **2** minute **0** M.
21. I hereby certify that I attended the deceased from **death**, 19____, to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death **Sunility** Duration
Due to.....

Due to.....
Other conditions **Fall No-9-3-48**
(Include pregnancy within 3 months of death)
Major injury
Major findings: Of operation **15.10.51**
Of autopsy **10.4**
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) **SUPPLEMENTARY INFORMATION REQUESTED**
(b) Date of occurrence **24**
(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
23. Signature **H. H. Beard** (M. D. or other) **Excelsior Springs**
Address **Excelsior Springs 9-13-48**

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

RECEIVED

District Health Officer No. 8.

District File Number.....

Date Filed 9-30-48

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 A. Moles

Licensed Embalmer No. 3296

P. O. Address Excelsior Springs 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. nov
Registrar's No. 79

Registration District No. 72

Primary Registration District No. 5291

1. PLACE OF DEATH:

(a) County Clay Rural
(b) City or town Rural
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME

Edward Erskine

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 Widowed

6. (b) Name of husband or wife _____

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

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: 80 Years
Months _____ Days _____
(if less than one day) _____ hr. _____ min.

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 _____
(Burial, cremation, or removal) (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov Year 1948 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 _____
Immediate cause of death _____

Due to _____

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) Accident

(b) Date of occurrence 9-2-1948

(c) Where did injury occur? Exterior Spine
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
On the street

While at work? _____ (Specify type of place)
(e) Means of injury Fall

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

MOTHER FATHER

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

S-29217