

Health,
Welfare
Public
Service

300
-56

Use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25871
STATE FILE NUMBER

FILED JUL 16 1957

Registration District No. 316 Primary Registration District No. 6075 Registrar's No. 216

1. PLACE OF DEATH a. COUNTY St. Francois				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Francois							
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Francois Twp.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN Flat River		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital #4			Length of stay in lb 48y, 6m, 12d		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) FANNIE				First FANNIE Middle EDMONDS Last EDMONDS		4. DATE OF DEATH Month June Day 27 Year 1957					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 10, 1882		9. AGE (In years last birthday) 74		IF UNDER 1 YEAR Months 6 Days 17 Hours Min. 		IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (City and state or country) Iron County, Mo.			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William F. Edmonds				14. MOTHER'S MAIDEN NAME Sarah Elizabeth Jones							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Address Records, State Hospital #4, Farmington, Mo.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis - - - - - instantaneously											
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) 420.1											
DUE TO (c) Imbecile with Huntington's Chorea.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2											
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. m. Month Day Year p. m. 											
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE			
21. I attended the deceased from April 1, 1925 to June 27, 1957 and last saw ^{her} you alive on June 27, 1957 Death occurred at 11:30 a. m. m. on the date stated above; and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <i>[Signature]</i> (Degree or title)				22b. ADDRESS Supt. State Hospital No. 4,				22c. DATE SIGNED 6-28-57			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 6-28-57		23c. NAME OF CEMETERY OR CREMATORY Washington Univ. Anat. Dept., St. Louis, Missouri		23d. LOCATION (City, town, or county) (State) St. Louis, Missouri					
24. FUNERAL DIRECTOR Cozean Funeral Home, Farmington, Mo.				25. DATE RECD. BY LOCAL REG. June 28, 1957		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

NOT EMBALMED.

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by Student Embalmer No. working under my personal supervision..

Student
Signature of Student Embalmer

Signed

Licensed Embalmer No.

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.