

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14881-58

58-017689
STATE FILE NUMBER

38

FILED JUN 6 1958 Registration District No. 96 Primary Registration District No. 5350 Registrar's No. _____

5. 300
1-57

1. PLACE OF DEATH a. COUNTY <u>Dallas</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Dallas</u> <u>6/30/58</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lincoln</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>- Rural - Lincoln</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b	d. STREET ADDRESS (If outside, give location)
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Rickey</u> Middle <u>James</u> Last <u>Edde</u>			4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>1958</u>		
---	--	--	---	--	--

5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>MAR-1-1958</u>	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months <u>2</u> Days <u>19</u>	IF UNDER 24 HRS. Hours _____ Min. _____
-----------------	---------------------------	--	------------------------------------	---------------------------------	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>URBANO, MO</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
---	-----------------------------------	--	--

13a. FATHER'S NAME <u>Wallace D. Edde</u>	13b. MOTHER'S MAIDEN NAME <u>Wilma L. Pains</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
---	---	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT <u>Wallace D. Edde - URBANO, MO</u> Address _____
---	-------------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	491X
	DUE TO (c) _____	
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"/> <u>2</u>

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. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT <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 <u>death on arrival</u> and last saw her/him alive on _____ Death occurred at <u>5:15 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.	
---	--

22a. SIGNATURE (Degree or title) <u>C. D. Bailey</u>	22b. ADDRESS <u>Urban, Mo</u>	22c. DATE SIGNED <u>May 24</u>
---	----------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>5-21-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Olive Point</u>	23d. LOCATION (City, town, or county) (State) <u>Hickory Co, MO</u>
--	-------------------------------	--	--

24. FUNERAL DIRECTOR <u>Allen W. Laughan</u>	ADDRESS <u>Urban, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>6/5/58</u>	26. REGISTRAR'S SIGNATURE <u>Miss Hazel Petree</u> by <u>PH</u>
---	-----------------------------	---	---

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

5. 300

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, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Allen W. Vaughan*

Licensed Embalmer No. *4156*
P. O. Address *Urbana, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.