

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-002001  
STATE FILE NUMBER

JAN 19 1959 Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 3

300  
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>Linn</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Chariton</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Brookfield</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Salisbury</b> <b>0210</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Doctors Hospital</b>		Length of stay in lb <b>1 day</b>	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 Middle Last <b>SHERI LINN EDGINGTON</b>			4. DATE OF DEATH Month Day Year <b>January 6, 1959</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 5, 1959</b>
9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min. <b>19 33</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Brookfield, Mo.</b>
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME <b>Robert Edgington</b>	
13b. MOTHER'S MAIDEN NAME <b>Grace Joy Ferguson</b>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Robert Edgington, Salisbury, Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Circulatory Collapse</b>			INTERVAL BETWEEN ONSET AND DEATH <b>19hrs 33 minutes</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Congenital heart defect</b>			
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"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>7545</b>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK	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 <b>Jan. 5, 1959</b> to <b>Jan. 6, 1959</b> and last saw her alive on <b>Jan. 6, 1959</b> Death occurred at <b>4:05 AM</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>John W. White, D. C.</b>		22b. ADDRESS <b>Brookfield, Mo.</b>	22c. DATE SIGNED <b>1/7/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Jan. 7, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Brookfield, Mo.</b>
24. FUNERAL DIRECTOR <b>Wright Funeral Home, Brookfield, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>1-10-59</b>	26. REGISTRAR'S SIGNATURE <b>Katharine Johnson Reg.</b>

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 *Harold B. Wright* .....

Licensed Embalmer No. *3718* .....  
P. O. Address *Brookfield* .....

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.