

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028892

FILED VS AUG 24 1959

STATE FILE NUMBER

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 106

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Harrel</u> | | 2. USUAL RESIDENCE (Where deceased lived, or institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Harrel</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) <u>West Plains</u> | | c. CITY OR TOWN <u>West Plains</u> | |
| Length of stay in (b) <u>1 yr</u> | | d. STREET ADDRESS (If outside, give location) <u>1122 Cass</u> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Memorial Hosp</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|---|---------------------------|--|--|---|--|
| 3. NAME OF DECEASED (Type or print) First <u>Wm</u> Middle <u>Geor</u> Last <u>Edmond</u> | | | 4. DATE OF DEATH Month <u>8</u> Day <u>8</u> Year <u>1959</u> | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-24-92 66</u> | 9. AGE (last birthday) <u>66</u> | IF UNDER 1 YEAR Months <u>7</u> Days <u>12</u> Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retail Merchant</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) <u>Richville, Mo.</u> | |
| 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | | 13a. FATHER'S NAME <u>G. J. Edmond</u> | | 13b. MOTHER'S MAIDEN NAME <u>Alice Carley</u> | |
| 14. NAME OF HUSBAND OR WIFE <u>Ethel Edmond</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes WW1</u> | | 16. SOCIAL SECURITY NO. <u>yes</u> | |
| 17. INFORMANT <u>Ethel Edmond</u> | | Address <u>West Plains Mo</u> | | | |

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|--|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| IMMEDIATE CAUSE (a) <u>Paralytic Ileus</u> | | | <u>24 hrs</u> | | |
| DUE TO (b) <u>Gastric Partial Resection</u> | | | <u>4 days</u> | | |
| DUE TO (c) <u>Perforated peptic ulcer</u> | | | <u>6 weeks</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>long-standing general debility</u> | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | |

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|---|--|----------------------------------|-----------------------------------|--|--------------|
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 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 <u></u> a.m. <u></u> p.m. <u></u> | Month, Day, Year | | | | |
| 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 8-1-59 to 8-8-59 and last saw him alive on 8-8-59
Death occurred at 5:25 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

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|--|-----------------------------|---|--|--|
| 22a. SIGNATURE (Degree or title) <u>W. J. Still M.D.</u> | | 22b. ADDRESS <u>West Plains Mo</u> | | 22c. DATE SIGNED <u>8/8/59</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Funeral Home</u> | 23b. DATE <u>8-20-59</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>San Leon</u> | | 23d. LOCATION (City, town, or county) (Style) <u>West Plains Mo</u> |
| 24. FUNERAL DIRECTOR <u>Funeral Home</u> | | 25. DATE RECD. BY LOCAL REG. <u>8-20-1959</u> | | 26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u> |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

100 85 001

8961

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed *D. S. Roberts*

Licensed Embalmer No. 343

P. O. Address *Lee St*

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.

SEP 9 1959