

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038998

FILED VS NOV 3 0 1959 042

Registration District No. \_\_\_\_\_ Primary Registration District No. 1000 Registrar's No. 1172

STATE FILE NUMBER

MAILED

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <i>Buchanan</i>	a. STATE <i>Missouri</i>		b. COUNTY <i>Andrew</i>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Joseph</i>	Length of stay in 1b	c. CITY OR TOWN <i>CAWOOD</i>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>General Osteopathic</i>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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 <i>John</i>	Middle	Last <i>Edelman</i>	4. DATE OF DEATH	Month <i>11</i>	Day <i>20</i>	Year <i>1959</i>
-------------------------------------	----------------------	--------	------------------------	------------------	--------------------	------------------	---------------------

5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>4-30-1889</i>	9. AGE (last birthday) <i>70</i>	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HR Hours	Min.
-----------------------	----------------------------------	---	--------------------------------------	-------------------------------------	---------------------------	------	-------------------------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED FARMER</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <i>Andrew Co. Mo</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>
--	-----------------------------------	--	--

13a. FATHER'S NAME <i>John Howard Edelman</i>	13b. MOTHER'S MAIDEN NAME <i>Margrete Leighton</i>	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) <i>yes</i>	16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT <i>Mrs. Minnie Hughes Belkors mo</i>	Address
--	--	---	---------

18/ CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <i>Cerebral anoxemia</i>		<i>40 minutes</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Coronary Embolism</i>	<i>12:50 P. M.</i>
	DUE TO (c) <i>Chest Trauma</i>	<i>12:50 P. M.</i>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Diabetes and Senility</i>	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
---	--

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <i>Automobile accident--car overturned. Patient thrown from car</i>
---	--	---

20c. TIME OF INJURY Hour a.m. p.m. <i>about 12:50 P. M.</i>	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.) <i>Curve East of Cawood Curve</i>	20f. CITY, TOWN, OR LOCATION <i>Andrew County</i>	COUNTY <i>Mo.</i>	STATE
---	--	---	--	----------------------	-------

21. I attended the deceased from <i>11-20-59</i> to _____ and last saw her/him alive on <i>11-20-59</i> Death occurred <i>5:45 P. M.</i> on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <i>H. H. Tespard</i>	(Degree or title)	22b. ADDRESS <i>1201 Jule Street</i>	22c. DATE SIGNED <i>11-24-59</i>
--	-------------------	---	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>	23b. DATE <i>11-20-1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Walnut Grove</i>	23d. LOCATION (City, town, or county) <i>NEAR REA MO</i>	(State)
---	--------------------------------	---	---	---------

24. FUNERAL DIRECTOR <i>Breit + HAWKINS SAVANNAH MO</i>	ADDRESS	25. DATE RECD. BY LOCAL REG. <i>Nov. 24, 1959</i>	26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Goodell</i>
--	---------	--	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS DEC 2 1959

MS DEC 9 1959

**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

*E. C. Breit*

Licensed Embalmer No. 2650

P. O. Address Savannah

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.