

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-014503

FILED VS APR 19 1960

STATE FILE NUMBER

Registration District No. 59 Primary Registration District No. 4097 Registrar's No. 77

1. PLACE OF DEATH a. COUNTY <u>CASS</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> COUNTY <u>CASS</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>HARRISONVILLE</u>		Length of stay in 1b <u>8 DAYS</u>	c. CITY OR TOWN <u>HARRISONVILLE</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Memorial Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>R#3</u>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>STELLA VICTORIA EDWARDS</u>			4. DATE OF DEATH Month Day Year <u>APRIL 11 1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>1-7-1888</u>	9. AGE (last birthday) <u>72</u> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home-maker</u>			10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>Jackson County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Robert TRAMILL</u>		13b. MOTHER'S MAIDEN NAME <u>Delia WALKER</u>		14. NAME OF HUSBAND OR WIFE <u>William E. EDWARDS</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. <u>NO</u>	17. INFORMANT Address <u>HARRISONVILLE</u> <u>William E EDWARDS RTS, MISSOURI</u>			
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>ARTERIO SCLEROTIC HEART DISEASE</u>					INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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) <u>Cerebral Arteriosclerosis</u>				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ a.m. _____ p.m. 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 <u>24th 1964</u> to <u>April 11, 1960</u> and last saw her <u>alive</u> on <u>April 10, 1960</u> Death occurred at <u>24th A</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>[Signature]</u> (Degree or title)			22b. ADDRESS <u>Harrisonville Mo</u>		22c. DATE SIGNED <u>11 April 1960</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>4-13-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Ridge Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Harrisonville, Missouri</u>			
24. FUNERAL DIRECTOR <u>Atkinson Dickey</u>		ADDRESS <u>HARRISONVILLE, MO.</u>	25. DATE RECD. BY LOCAL REG. <u>April 13-1960</u>	26. REGISTRAR'S SIGNATURE <u>Ma Ray Sebrer</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Robert W. Ackerson

Licensed Embalmer No. 4902

P. O. Address Sumner

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.