

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUN 1 1960

=60-022102

STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 109

1. PLACE OF DEATH a. COUNTY <b>VERNON</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Polk</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Washington Township</b>	Length of stay in 1b <b>18yrs. 4mo. 10d</b>	c. CITY OR TOWN <b>Sentinel</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hosp #3</b>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Name</b>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Era</b> Middle <b>UNA</b> Last <b>Edmondson</b>			4. DATE OF DEATH Month <b>May</b> Day <b>19</b> Year <b>1960</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>Dec. 27, 1891</b>	9. AGE (last birthday) <b>68 yr. 4mo 20d</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>	11. BIRTHPLACE (City and state or country) <b>Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
13a. FATHER'S NAME <b>Wm B Edmondson</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Mitchell</b>		14. NAME OF HUSBAND OR WIFE <b>Single</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>UNK</b>		16. SOCIAL SECURITY NO. <b>UNK</b>	17. INFORMANT Address <b>Records, State Hosp # Nevada, Mo</b>		

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) <b>CORONARY Occlusion</b>		<b>Sudden</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Generalized Arteriosclerosis</b>	<b>Several Years</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)		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 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 **January 8, 1942** to **May 19, 1960** and last saw her <sup>her</sup> alive on **May 19, 1960**  
Death occurred at **7:40 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Leslie H Wright, M.D.</b>		22b. ADDRESS <b>State Hosp #3 Nevada, Mo</b>		22c. DATE SIGNED <b>5/19/60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>May 21, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Maere Cemetery</b>	23d. LOCATION (City, town, or county) <b>Nevada Missouri</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Larry L. Linn, Nevada</b>		25. DATE RECD. BY LOCAL REG. <b>5-28-60</b>	26. REGISTRAR'S SIGNATURE <b>Anna J. Jurey</b>	

(Licensed Embalmer's Statement on Reverse Side)

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 L. August Ferry

Licensed Embalmer No. 4960

P. O. Address Newada, T

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.