

# R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. SEP 26 1960

149

Registration District No. \_\_\_\_\_ Primary Registration District No. 1002

Registrar's No. \_\_\_\_\_

4629-60-024724

STATE OF MISSOURI

DED

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>50 yrs.</b>		c. CITY OR TOWN <b>Kansas City</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>Osteopathic Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>2304 Bellfontaine</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>MR. DAVID</b> Middle <b>B.</b> Last <b>EDWARDS</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>4,</b> Year <b>1960</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>5-17-1885</b>		9. AGE (last birthday) <b>75</b>		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) <b>Carpenter-retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home Building</b>		11. BIRTHPLACE (City and state or country) <b>Akerman, Mississippi</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>					
13a. FATHER'S NAME <b>Jim M. Edwards</b>				13b. MOTHER'S MAIDEN NAME <b>Alice Marie Snelling</b>				14. NAME OF HUSBAND OR WIFE <b>Anna M. Edwards</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>499-07-2902</b>		17. INFORMANT Address <b>Mrs. Donald M. Jades-6333 Blue Ridge</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>Pulmonary edema</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Pulmonary embolism + thrombosis</b> DUE TO (c) <b>atherosclerosis, obstructive uropathy</b>										INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b> <b>12 hrs</b> <b>years</b>			
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			
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 _____ Month, Day, Year _____ a.m. _____ p.m. _____													
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <b>9-3-60</b> to <b>9-4-60</b> and last saw <sup>her</sup> him live on <b>9-4-60</b> Death occurred at <b>6:25 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <b>Grover N. Gillum MD.</b> (Degree or title)						22b. ADDRESS <b>926-E-17th St</b>			22c. DATE SIGNED <b>9/6/60</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9-7-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City, town, or county) <b>Kansas City, Missouri</b>		(State)					
24. FUNERAL DIRECTOR <b>Mellody-McGilley-Eylar -1800 E. Linwood Bld.</b> ADDRESS				25. DATE RECD. BY LOCAL REG. <b>9-10-60</b>		26. REGISTRAR'S SIGNATURE <b>H. L. Dwyer</b>							

DOCUMENT

BY AFFIDAVIT OF  
Grover N. Gillum  
MEDICAL CERTIFICATION

D. H. S.  
926 E.  
DR 1-14  
J. Dec. 12  
Osteopath  
445

**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 Arthur Eugene Hall

Licensed Embalmer No. 491  
P. O. Address 16 C. M.

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.