

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

43

Primary Registration District No.

3007

Registrar's No.

304

-61-032032

STATE FILE NUMBER

AMENDED

Registration District No. **FILED SEP 18 1961**

1. PLACE OF DEATH a. COUNTY BUTLER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY STODDARD	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF		Length of stay in 1b 125 DAYS	c. CITY OR TOWN BLOOMFIELD Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) NONE Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First ODEN Middle VERNON Last EDWARDS			4. DATE OF DEATH Month SEPTEMBER Day 6 Year 1961	
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5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/11/93	9. AGE (last birthday) 67	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	10b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE	11. BIRTHPLACE (City and state or country) DEXTER, MISSOURI	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME TOM EDWARDS	13b. MOTHER'S MAIDEN NAME MOLLY SUTHERLAND	14. NAME OF HUSBAND OR WIFE DECEASED
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WWI	16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT Address VA HOSPITAL RECORDS, POPLAR BLUFF, MO.
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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: IMMEDIATE CAUSE (a) CACHEXIA.		INTERVAL BETWEEN ONSET AND DEATH Course of hospitalization.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) GENERALIZED METASTASES.	
	DUE TO (c) RENAL ADENO CARCINOMA.	

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.)
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20c. TIME OF INJURY Hour VA Month, Day, Year May 4, 1961 a.m. p.m.	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 VA	COUNTY	STATE
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21. attended the deceased from **May 4, 1961** to **Sept. 6, 1961** and last saw her/him **him**
Death occurred at **11:10PM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (In green or blue) M. V. MALINOSKI, M.D., Actg. Chief, Surg. Svc. VA Hospital, Poplar Bluff, Mo.	22b. ADDRESS Aid, Missouri	22c. DATE SIGNED 9-7-61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Sept. 9-61	23c. NAME OF CEMETERY OR CREMATORY Harper cemetery	23d. LOCATION (City, town, or county) (State) Aid, Missouri
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24. FUNERAL DIRECTOR CHILES UND. CO. BLOOMFIELD, MO.	25. DATE/RECD. BY LOCAL REG. 9/16/1961	26. REGISTRAR'S SIGNATURE Shelma Graham
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 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 me,

& by Lulu Cooper # 3499

~~XXXXXX~~

~~XXXXXX~~

Student _____

Signature of Student Embalmer

Signed: Juan C. Cooper

Licensed Embalmer No. 4119

P. O. Address Bloomfield, Mo.

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.