

FILED AUG 1 1946

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

24389 68

1. PLACE OF DEATH

County Moniteau  
Township Lepton  
City (No.) \_\_\_\_\_

Registration District No. 225  
Primary Registration District No. 4335

File No. \_\_\_\_\_  
Registered No. 9 Ward 0

2. FULL NAME Abubael D. Edwards

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6-22-1859  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 87 1 1

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) north Carolina

13. NAME Daniel W. Edwards

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) north Carolina

15. MAIDEN NAME Donald

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) north Carolina

17. INFORMANT (ADDRESS) A. C. Edwards  
Tipton, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Int Zion Cem. DATE 7-25-46

19. UNDERTAKER (ADDRESS) C. Albert Hornbeek  
Prairie Home, Mo.

20. FILED July 24 1946 Mrs. Maud Hudson Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 23, 1946  
22. I HEREBY CERTIFY, That I attended deceased from May 15, 1946 to July 23, 1946  
I last saw him live on July 23, 1946 Death is said to have occurred on the date stated above, at 3 P. m.  
The principal cause of death and related causes of importance were as follows:

hypostatic pneumonia  
Other contributory causes of importance: ADD: UNAL  
Fract. L. Hip SUPPLEMENTARY  
INFORMATION  
REQUESTED 5-17-46

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place. 6?  
Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_  
(Signed) J. F. Potts, M. D.  
(Address) Tipton, Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified.

Or Defers  
4<sup>th</sup> Ohio

RECEIVED  
District Health Officer No.  
District File Number  
Date Filed 7-29-46

Registration District No. 225

Primary Registration District No. 4335

Registrar's No. 9

1. PLACE OF DEATH:

(a) County Montana  
(b) City or town Tipton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Shubal O. Edward

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased June 22  
(Month) (Day) (Year)

8. AGE: Years 87 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town or county) \_\_\_\_\_ (State or foreign country) N.C.

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day 23 Year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence May 17/46

(c) Where did injury occur? Tipton Montana road  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury Fall

23. Signature A. F. Potts (M. D. or other) \_\_\_\_\_

Address Tipton, Mo. 646 Date signed \_\_\_\_\_

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—WRITE

24389