

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

Do not use this space.

✓
40300

1. PLACE OF DEATH

County.....
Towship.....
City..... *St Louis, Mo*

Registration District No. *791*
Primary Registration District No. *1003*

File No.....
Registered No. *12341*
St..... Ward.....

2. FULL NAME

Richard Edwards
(a) Residence, No. *5733 Benedick* St., *9* Ward.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred *40* yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *negro* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) *Widowed*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *March 17, 1875*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<i>51</i>	<i>90</i>	<i>8</i>		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *laborer*
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Texas*

10. NAME OF FATHER *Richard Edwards*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Mississippi*

12. MAIDEN NAME OF MOTHER *Julia*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Texas*

14. INFORMANT (Address) *Anna J. Woodard City Hospital #2*

15. FILED *DEC 29 1926* *Man Starcoff* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec. 25 1926*
17. I HEREBY CERTIFY That I attended deceased from *Dec 25* 19*26* to *Dec 30* 19*26* that I last saw him *alive* on *Dec 25* 19*26* and that death occurred, on the date stated above, at *11:30* a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis
131
93C (duration) _____ yrs. mos. da.
CONTRIBUTORY *Chronic nephritis* (SECONDARY) (duration) *Indefinite* da.

18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical & Laboratory*
(Signed) *J. W. Gray*, M. D.
12/27, 1926 (Address) *City North Mo*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Friedens Cem* DATE OF BURIAL *12/29 1926*

20. UNDERTAKER *Russell and Co* ADDRESS *27 1/2 Pine*

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

