

DEC 12 1938

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

37622
Do not use this space.**1. PLACE OF DEATH**

(a) County..... / Registration District No. **791**
 (b) Township..... / Primary Registration District No. **1003**
 (c) City..... **St. Louis** (d) Street No. **City Hospital No. 1** St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. **9949****2. PRINT FULL NAME**

D. 11 683 363 James Edwards
 (a) Residence, No. **Ozanam Shelter, 11** (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS**MEDICAL CERTIFICATE OF DEATH**

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*) **single**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **11/12/38** 19

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

22. I HEREBY CERTIFY, That I attended deceased from **11/9/38**, 19... to **11/12/38**, 19...
I last saw him alive on **11/12/38**, 19... Death is said6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Not Known**to have occurred on the date stated above, at **9.55 p.**
The principal cause of death and related causes of importance were as follows:

7. AGE **65** YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

Date of onset

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

Cerebral hemorrhage
hypertensive heart disease
Syphilitic aortitis
34

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis, Missouri**

Other contributory causes of importance:

13. NAME **Not Known**

Broncho pneumonia
Generalized arteriosclerosis
Multiple cysts of kidneys
Non-infectious

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Not Known**

Name of operation..... Date of.....

15. MAIDEN NAME

What test confirmed diagnosis?..... Was there an autopsy? **yes**16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Not Known**

23. If death was due to external causes (violence), fill in also the following:

17. INFORMANT **Hosp. Info M. Kent** (ADDRESS)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.18. BURIAL, CREMATION, OR REMOVAL PLACE **Calvary** DATE **Nov 19** 19**38**Manner of injury.....
Nature of injury.....19. FUNERAL DIRECTOR (NAME) (ADDRESS) **J. J. Prebeck** **2843**24. Was disease or injury in any way related to occupation of deceased? **1**
If so, specify..... (Signed) **Dr. Maxwell**, M. D.
(Address) **City Hospital No. 1**20. FILED **NOV 18 1938** **J. J. Prebeck** Local Registrar.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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,

No Embalming
....., or by

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.