1 1939 REC'D APR 7 1939

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

12263
Do not use this space.

1. PLACE OF DEATH
(a) County St Louis
(b) Township or (c) City Kirkwood
Registration District No. 784
Primary Registration District No. 106
Registered No. 586
(d) Street No. 1726 W. Woodbine 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. 4 mos. 10 ds. (f) How long in U. S., if of foreign birth? — yrs. — mos. — ds.

2. PRINT FULL NAME Homer Elmer Edwards.
(a) Residence, No. ..... St.
(Usual place of abode, if no street address, write county or city) (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): Married
5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF Mable S. Edwards.
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 7-30-1909
7. AGE: Years 30 Months 2 Days 1 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Laborer
9. Industry or business in which work was done, as saw mill, bank, etc. Nursery.
10. Date deceased last worked at this occupation (month and year) Oct. 1936
11. Total time (years) spent in this occupation 5 yr.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cuba Mo.

FATHER
13. NAME Stephen Edwards.
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) La

MOTHER
15. MAIDEN NAME Minnie Myers.
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark.

17. INFORMANT Mrs. B. F. Stuffleu
(ADDRESS) Augusta Mo.
18. BURIAL, CREMATION, OR REMOVAL
PLACE St Mary's Cem. DATE 4-2 1939
19. FUNERAL DIRECTOR (NAME) Maurice McCleary
(ADDRESS) Hamburg & Howell — Mo.
20. FILED ..... 19..... MAR 31 1939 R. R. Meyer M.D. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 31 1939
22. I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1939, to Mar. 31, 1939
I last saw him alive on March 28, 1939. Death is said to have occurred on the date stated above, at 4:17 m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Melanosarcoma	4/1/38
Barnard S.K.U. Conv. Hospital for complete report on this case	

Other contributory causes of importance:

Name of operation Biopsy Date of 1938
What test confirmed diagnosis? Was there an autopsy? No.

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.
Manner of injury —
Nature of injury —

24. Was disease or injury in any way related to occupation of deceased? No.
If so, specify
(Signed) Hale Lofman, M. D.
(Address) 362 N. Lay Ave. Kirkwood Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.

50M-9-10-38 I X16605

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MAR 30 1954

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, 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.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

12263-X
Do not use this space.

1. PLACE OF DEATH
(a) County St. Louis — Registration District No. 784
(b) Township — Primary Registration District No. 10 — Registered No. 586
(c) City Kirkwood (d) Street No. ..... 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.

2. PRINT FULL NAME Homer E. Edwards
(a) Residence, No. 1724 W. Woodline St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*): M-

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
30	2	1	

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.
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)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE ..... DATE ..... 19..

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 3-31, 1939 T.R. Mayo M.D. P.H. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 31, 1939

22. I HEREBY CERTIFY, That I attended deceased from ....., 19.., to ....., 19..
I last saw him alive on ....., 19.. Death is said to have occurred on the date stated above, at ....m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Melanotic Sarcoma	4-1-38
Thoughtness leading upon the taking of coffee food.	
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Other contributory causes of importance:
Barnard Skin + Cancer Hosp for complete record on case.

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.

Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) John Lefgreen, M. D.
(Address) Kirkwood Mo.
300 N. Taylor Ave.

SUPPLEMENTARY

ROWENA MOORE

WHITE PAPER, WITH SPACING INDICATING IT 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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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