

Registration District No. **757** Primary Registration District No. **3036**

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County **St. Charles**
(b) City or town **St. Charles**
(c) Name of hospital or institution **St. Joseph's Hospital**
(d) Length of stay: In hospital or institution **63**
In this community **65 days**

8. (a) PRINT FULL NAME **Edward Henry Edinger**
8. (b) If veteran, name war **World War**
3. (c) Social Security No. **none**

4. Sex **Male** **5. Color or race** **White** **6. (a) Single, widowed, married, divorced** **Married**
6. (b) Name of husband or wife **Mrs. Schmidt Edinger** **6. (c) Age of husband or wife if alive** **Don't know**
7. Birth date of deceased **July 7 1895**

8. AGE: Years **44** Months **6** Days **8** If less than one day **hr. min.**

9. Birthplace **Linn, Mo.**

10. Usual occupation **Farmer**

11. Industry or business
12. Name **Henry Edinger**
13. Birthplace **Don't know Germany**
14. Maiden name **Don't know**
15. Birthplace **" "**

16. (a) Informant **Frank Edinger**
(b) Address **Wentzville, Mo.**

17. (a) Place of burial or cremation **Wentzville, Mo.**
(b) Date thereof **11/18/40**

18. (a) Signature of funeral director **W. Papadopoulos**
(b) Address **Wentzville, Mo.**

19. (a) Date received local registrar **1/17/40** **(b) Registrar's signature** **Clarence H. Mueller**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **St. Charles**
(c) City or town **Wentzville Rural**
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Jan** day **15** year **1940** hour **11** minute **15 P.M.**
21. I hereby certify that I attended the deceased from **June 1932** to **Jan 15 1940**
that I last saw him alive on **Jan 11 1940** and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia**
Duration **4 days**

Due to **lung abscess** **NOV 12 '40**
Empyema
Due to **Pleurisy** **OCT. 12 '40**

Other conditions (include pregnancy within 3 months of death)
Major findings: **Ret. Retention**
Of operations
Of autopsy **No**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **no**
(b) Date of occurrence **no**
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **no**

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **Vincent A. Schmidt** (M. D. or other) **1**
Address **St. Charles** **Date signed** **Jan 18 '40**

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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. 2711

P. O. Address Wrightville, N.C.

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

35-49 7
Do not use this space.

1. PLACE OF DEATH
 (a) County St Charles Registration District No. 357
 (b) Township St Charles Primary Registration District No. 3036 Registered No. _____
 (c) City St Charles (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (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 Eduard Henry Edinger
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

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.
44 6 8

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 _____

FATHER
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 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 _____ 19_____
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-13-1940

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

I last saw h. _____ 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:
Pneumonia Bronchial Date of onset 12/30/39
lung abscess
Empyema
Pleurisy
 Other contributory causes of importance: 110 W

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) Vincent A. Schneider D. _____
 (Address) St Charles _____

SUPPLEMENT

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.

