

FILED OCT 21 1942

State File No. ....

Registration District No. ....

Primary Registration District No. 1003

Registrar's No. 8499

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

1. PLACE OF DEATH:

(a) County  
(b) City or town ST LOUIS  
(c) Name of hospital or institution:  
2935 LACLED AVE.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.  
In this community 20 YRS.  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County  
(c) City or town ST LOUIS 21?  
(d) Street No. 2935 LACLED AVE.  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Johnnie Edwards.

3. (b) If veteran, name war World War 3. (c) Social Security No. No.

4. Sex MALE 5. Color C 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Gertrude 6. (c) Age of husband or wife if alive 40 years  
7. Birth date of deceased 10-2-1894  
(Month) (Day) (Year)

8. AGE: 48 years 0 Months 9 Days If less than one day hr. min.

9. Birthplace MARINE MISSI  
(City, town, or county) (State or foreign country)

10. Usual occupation LABORER

11. Industry or business

MOTHER FATHER { 12. Name John Higgins  
13. Birthplace UNKNOWN  
14. Maiden name " " " "  
15. Birthplace " " " " (City, town, or county) (State or foreign country)

16. (a) Informant Gertrude Edwards  
(b) Address 2935 Laclede

17. (a) (BURIAL) (b) Date thereof 10-16-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation National Cemetery

18. (a) Signature of funeral director James J. ...  
(b) Address 3103 Washington

19. (a) OCT 14 1942 (b) J. F. ...  
(Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 11th,  
year 1942 hour 8:47 minute A. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, 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 Cerebral Hemorrhage;  
Chronic Hypertrophic Myocarditis;

Due to Fluorosis  
Due to 92nd  
Other conditions (Include pregnancy within 3 months of death)

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

Duration  
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) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(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?

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

23. Signature Walter Perry (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed 10/13/42

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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..... *William Claude Gordo* .....

Licensed Embalmer No..... *3489* .....

P. O. Address..... *2649 Delmar* .....

**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, fact should be so stated above.**