. S. No. 2
OM—5-42
5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 19 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

1005

State File No. 12082

Registration District No. ..... Primary Registration District No. ..... Registrar's No. 3229

1. PLACE OF DEATH:

(a) County .....

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis Childreas Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Jefferson

(c) City or town Belle Rive
(If outside city or town limits, write "RURAL")

(d) Street No. .....
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME Edmison, Judith Sharon

3. (b) If veteran, name war .....

3. (c) Social Security No. none

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife .....

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased September (Month) 4 (Day) 1942 (Year)

8. AGE: Years ~~1~~ Months 6 Days 29 If less than one day ..... hr. ..... min.

9. Birthplace Keenes (City, town, or county) Illinois (State or foreign country)

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name Conrad ~~Edmiston~~ Edmison
13. Birthplace Keenes (City, town, or county) Illinois (State or foreign country)

MOTHER
14. Maiden name Norma Keen
15. Birthplace Keenes (City, town, or county) Illinois (State or foreign country)

16. (a) Informant Conrad ~~Edmiston~~ Edmison
(b) Address Keenes, Illinois

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/6/43 (Month) (Day) (Year)
(c) Place: burial or cremation Keenes Ill.

18. (a) Signature of funeral director Albert H. Hoppe Inc.
(b) Address 4700 Washington Blvd.

19. (a) APR 5 1943 (Date received local registrar) (b) J. F. Bridek (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 3
year 1943 hour 10 minute 38 P.M.

21. I hereby certify that I attended the deceased from 3
30, 1943, to 4-3, 1943;
that I last saw her alive on 4-3, 1943;
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac & respiratory failure

Due to Influenzal meningitis hydrocephalus

Due to 35

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

23. Signature R. J. Blattner (M. D. or other)
Address 500 So. Kingsbury Date signed .....

(Licensed Embalmer's Statement on Reverse Side)

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.....3575.....

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, fact should be so stated above.