

FILED DEC 22 1943

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **10748**

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: **Homer G. Phillips Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. **4 Hours**
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **2818 Thomas St.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Egbert Edwards**

3. (b) If veteran, name war **World 1** 3. (c) Social Security No. **495-12-7306**

4. Sex **Male** 5. Color or race **Col** 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. **April 24, 1897**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
46 **7** **9** _____ hr. _____ min.

9. Birthplace **Tennessee**
(City, town, or county) (State or foreign country)

10. Usual occupation **Unemployed**

11. Industry or business _____

MOTHER FATHER { 12. Name **William Edwards**
13. Birthplace **N. Carolina**
14. Maiden name **Mary Belle**
15. Birthplace **Tenn**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mary B. Edwards**
(b) Address **2818 Thomas Street**

17. (a) **Burial** (b) Date thereof **12/8/43**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Jefferson Barracks**

18. (a) Signature of funeral director **R. M. C. Green**
(b) Address **3517 Laclede Avenue**

19. (a) **DEC 7 1943** (Date received local registrar) **J. F. Brubaker** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **3** year **1943** hour **7** minute _____ P. 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

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Duration

PHYSICIAN

Major findings: _____
Of operations _____
Of autopsy _____

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 place) (e) Means of injury? _____

23. Signature **Thomas F. Callahan** (Physician's name) _____
Address **Deputy Coroner** (Date signed **12-7-43**)

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

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. 1173

P. O. Address. 3517 S. Leland Ave

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.