

FILED APR 6 1945

318

Primary Registration District No.

1003

Registrar's No. 2849

1. PLACE OF DEATH:

(a) County.....

(b) City or town St. Louis, Missouri  
(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 3 mos., 8 days  
(Specify whether)

In this community 23 years  
years, months or days

3. (a) PRINT FULL NAME George Edwards

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

3. (c) Social Security No.....

4. Sex Male

5. Color or race Colored

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 16, 1898  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

46 10 21 hr. min.

9. Birthplace: North Carolina  
(City, town, or county) (State or foreign country)

10. Usual occupation: Laborer

11. Industry or business: George Edwards

MOTHER FATHER

12. Name George Edwards

13. Birthplace N.C.  
(City, town, or county) (State or foreign country)

14. Maiden name Carrie

15. Birthplace N.C.  
(City, town, or county) (State or foreign country)

16. (a) Informant Shirley M. Smith

(b) Address 2601 N. Whittier

17. (a) Anatomical Board Date thereof Mar 14 45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director: J. F. Buseck

(b) Address: 3530 Kenton

19. (a) MAR 29 1945 (Date received local Registrar)  
J. F. Buseck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis,  
(If outside city or town limits, write "RURAL") 17 19

(d) Street No. 4139 Delmar Blvd.  
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 7,  
year 1945 hour 5 minute 40 A. M.

21. I hereby certify that I attended the deceased from November 27, 1945, to March 7, 1945  
that I last saw h. in alive on March 7, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary Tuberculosis (far advanced) Unk.

Due to.....

Due to.....

Other conditions: 13  
(Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

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 place)

(e) Means of injury.....

23. Signature Shirley M. Smith (M. D. or other)  
Address 2601 N. Whittier Date signed 3/25/45

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

100  
17  
9

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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.....

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.**