

S. No. 2
M-5-43
v. 5-17-39
A I X36671

DEPARTMENT OF COMMERCE THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF THE CENSUS

FILED NOV 10 1945 STANDARD CERTIFICATE OF DEATH

31836

State File No. _____

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 9462

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis

(c) Name of hospital or institution:
4001 Washington Blvd. /
(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 Missouri (b) County 000

(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 19 / 1

(d) Street No. 4001 Washington Blvd.
(If rural, give location) 9

(e) Citizen of foreign country? _____ (Yes or No) 0

If yes, name country _____

3. (a) PRINT FULL NAME Elzan Edwards

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 1
year 1945 hour 6:45 minute A.M. M.

21. I hereby certify that I attended the deceased from
Sept 23 1945, to Oct 31 1945;
that I last saw h. er. alive on Oct 31 1945;
and that death occurred on the date and hour stated above.

4. Sex Female /

5. Color or race White

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

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

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

7. Birth date of deceased October 8 1868
(Month) (Day) (Year)

Immediate cause of death Carcinoma of colon 18 mo.

Due to _____

Due to _____

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

Major findings: Of operations

Of autopsy _____

8. AGE:	Years	Months	Days	If less than one day
	<u>77</u>	<u>0</u>	<u>23</u>	hr. _____ min. _____

9. Birthplace Indiana /
(City, town, or county) (State or foreign country)

10. Usual occupation At home

11. Industry or business _____

MOTHER FATHER { 12. Name David Kline

13. Birthplace Indiana /
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Indiana /
(City, town, or county) (State or foreign country)

16. (a) Informant MILDRED EDWARDS

(b) Address 4001 WASHINGTON

17. (a) REMOVAL (b) Date thereof 11-4-1945
(burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak WOOD CEMETERY

18. (a) Signature of funeral director Hermon Rindkeff

(b) Address 5216 Delmar Blvd.

19. (a) NOV 1 1945 (b) J. F. Bredenk
(Date received local registrar) (Registrar's signature)

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 Newton John Eversall (M. D. or other) M.D.
Address 4129 Washington Rd Date signed 11-1-45

PHYSICIAN
Underline the cause to which death should be charged statistically.

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.....

H. Burgess
4029

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.