No. 2
-1/47
-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 25496

FILED AUG 8 1947

Registration District No. 8

Primary Registration District No. 1003

Registrar's No. 6960

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: CITY HOSPITAL (If not in hospital or institution, write street number or location)

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

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County

(c) City or town ST. LOUIS (If outside city or town limits, write "RURAL")

(d) Street No. 2716 MISSOURI AV. (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME JAMES D. EDSTER.

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex MALE

5. Color or race W

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

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

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

7. Birth date of deceased FEB. (Month) 20 (Day) 1882 (Year)

8. AGE: Years 65 Months 5 Days 5 If less than one day hr. min.

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

10. Usual occupation NIL

11. Industry or business

MOTHER FATHER

12. Name UNKNOWN EDSTER

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

14. Maiden name UNKNOWN

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

16. (a) Informant Mrs Bernice Drees

(b) Address 2914 A Lemp av.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JULY 29/47 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director E. J. Schnur

(b) Address 3125 Lafayette Av.

19. (a) JUL 26 1947 (Date received local registrar) (b) E. F. Breece (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 25 year 1947 hour 8 11 minute 30 p. M.

21. I hereby certify that I attended the deceased from, 19, to, 19; that I last saw h alive on, 19; and that death occurred on the date and hour stated above.

Immediate cause of death: Acute cerebral hemorrhage

Due to: caused by fractured femur when he fell from the roof

Due to: Died at home on July 25 1947 about 9:00 P.M.

Due to:

Other conditions (Include pregnancy within 3 months of death): 186

Major findings: Of operations: 28

Of autopsy: 28

Duration

PHYSICIAN

Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence July 25 1947

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home or farm, in industrial place, in public place? Home (Specify type of place)

While at work (e) Means of injury Fall

23. Signature Wm. E. Taylor (M. D. or other)

Address Date signed 7/26/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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

Final

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 Jos B. Vollmer

Licensed Embalmer No. 4014

P. O. Address 3125 Lafayette

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.