FEDERAL SECURITY AGENCY
U. S. National Office of Vital Statistics

FILED NOV 20 1947

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 39323

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 189

1. PLACE OF DEATH:
(a) County St Charles
(b) City or town St. Charles Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 1907 North 3 St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 80-Yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 92
(c) City or town St. Louis St Charles 9
(If outside city or town limits, write "RURAL")
(d) Street No. 1907 N. 3 St. 3
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country (1)

3. (a) PRINT FULL NAME Phoebe Edwards
3. (b) If veteran, name war ..... 3. (c) Social Security No. none
4. Sex 3 Female 5. Color or race Negro 2 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife ..... 6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased unknown (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
abt 87			..... hr. ..... min.

9. Birthplace ..... (City, town, or county) MOV (State or foreign country)
10. Usual occupation Domestic
11. Industry or business .....
FATHER
12. Name Eli Kelln
13. Birthplace ..... (City, town, or county) Mo. 0 (State or foreign country)
MOTHER
14. Maiden name unknown
15. Birthplace ..... (City, town, or county) Mo. 0 (State or foreign country)
16. (a) Informant John Wise
(b) Address 1907 N. 3 St.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-7-47 (Month) (Day) (Year)
(c) Place: burial or cremation Oak Grove Cemetery
18. (a) Signature of funeral director Atkins Bros
(b) Address 3644 Finney ave
19. (a) 11-9-47 (Date received local registrar) (b) Fannie Hamilton (Registrar's signature) 394

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 4th year 1947 hour 6 minute 45 A.M.

21. I hereby certify that I attended the deceased from July 1, 1947, to Nov. 3rd, 1947 that I last saw her alive on Nov 3rd, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Myocardiles	
Due to Senilities	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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) .....
(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 A. H. Tyler (M. D. or other)
Address 200 N. Main St St Charles Mo Date signed Nov 4-47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed NOV 19 1947

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 Louis V. Atkin

Licensed Embalmer No. 2842

P. O. Address 3644 Fim

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.

B
15
3880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Dec

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 189

1. PLACE OF DEATH:

(a) County St Charles

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

(c) Name of hospital or institution:

(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 (b) County

(c) City or town
(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 Phoebe Edwards

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race B

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

6. (b) Name of husband or wife

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

7. Birth date of deceased unk (Month) (Day) (Year)

8. AGE: Years 87 Months Days If less than one day hr. min.

9. Birthplace St Charles Missouri (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month year 1947 hour minute 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 — *Duration*

Due to

Due to

Other conditions
(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

39323