

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

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FEDERAL SECURITY AGENCY

National Office of Vital Statistics

FILED JUL 28 1948

Registration District No. 518

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 24247

Registrar's No. 6370

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Anthony Hospital
(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

3. (a) PRINT FULL NAME Charlotte Edwards

3. (b) If veteran, name war -- 3. (c) Social Security No. --

4. Sex Female 5. Color or race White 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: July 12 1948
(Month) (Day) (Year)

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

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

10. Usual occupation Nil

MOTHER FATHER

11. Industry or business _____

12. Name Max W. Edwards

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

14. Maiden name Charlotte Edwards

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

16. (a) Informant Charlotte Edwards

(b) Address 1829 S. 7th St.

17. (a) Burial (b) Date thereof 7/19/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation SS Peter & Paul Cem.

18. (a) Signature of funeral director Wacker - Velderte

(b) Address 3634 Gravois Ave.

19. (a) JUL 19 1948 (b) J. F. Bredack
(Date received local registrar) (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
(d) Street No. 1829 S. 7th St. (If rural, give location) 9
23 (e) Citizen of foreign country? _____ (Yes or No) 0
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 17
year 1948 hour 4 minute 45 P.M.

21. I hereby certify that I attended the deceased from July 12 1948 to July 17 1948
that I last saw her alive on July 17 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Failure of
Congenitally Malformed Heart. Duration _____

Due to 157 e

Other conditions Intestinal Obstruction (Congenital)
(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 John W. Wacker (M. D. or other) M.D.
Address 3305 S. Grand Date signed 7/19/48

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.

no
Embalming

Signed *Delid J. Krupar*
Licensed Embalmer No. *3497*
P. O. Address *3634 Garrison*

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.