

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

27570

FILED AUG 28 1948
Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

7187

1. PLACE OF DEATH:

(a) County.....
(b) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Deaconess Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 weeks
(Specify whether
In this community
years, months or days)

3. (a) PRINT
FULL NAME Edith F. Cadle
(b) If veteran, name war.....
3. (c) Social Security No.
490-14-6414

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife James Cadle
6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased February 24 1920
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
28 5 21 hr. min.

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

10. Usual occupation Stenographer

11. Industry or business Aloe & Co.

12. Name Robert W. Henning

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

14. Maiden name Widel

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

16. (a) Informant Robert W. Henning
(b) Address 4 Pleasant Ct. Kirkwood Mo.

17. (a) Burial (b) Date thereof 8/17/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill Cemetery

18. (a) Signature of funeral director Meyer-Pfützinger

(b) Address Kirkwood 22 Mo.

19. (a) AUG 16 1948 (b) J. F. Ordeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Kirkwood 22 R.R. 13
(If outside city or town limits, write "RURAL")
(d) Street N.R. #4 Treecourt Lane
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 15
year 1948 hour 3 minute 30 A. M.

21. I hereby certify that I attended the deceased from
July 2, 1948, to August 15, 1948;
that I last saw her alive on August 14, 1948;
and that death occurred on the date and hour stated above.

Immediate cause of death
Thrombocytopenic Purpura 2 1/2 mo.

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? (b) Means of injury.....

23. Signature E. P. A. Sheffler (M. D. or other)
Address 634 N. Grand St. St. Louis, Mo. Date signed 8-16-48

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.

Signed.....

John M. Meyer

Licensed Embalmer No.

23288

P. O. Address

Kirkwood, Mo

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.