

FILED OCT 18 1948

State File No. \_\_\_\_\_

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **8645**

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: Barnes Hospital, D  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 13 DAYS (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard 103  
(c) City or town Bloomfield  
(If outside city or town limits, write "RURAL")  
(d) Street No. NR (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

CHARLES BOYD EDWARDS

3. (b) If veteran, name war

No

3. (c) Social Security No.

None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Bertha Edwards 6. (c) Age of husband or wife if alive 48 years  
7. Birth date of deceased November 30 1886  
(Month) (Day) (Year)

8. AGE: Years 61 Months 10' Days 2 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Stoddard County Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Farming

MOTHER FATHER { 12. Name John Farmer Edwards  
13. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Bertha Edwards  
(b) Address Bloomfield, Missouri

17. (a) Burial (b) Date thereof 10/3/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bloomfield, Missouri

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) OCT 4 1948 (b) J. J. Brodack  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT, day 2  
year 1948 hour 7/30 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from SEPT. 19  
\_\_\_\_\_, 19 48 to OCT 2, 1948:

that I last saw him alive on OCT 2, 1948:  
and that death occurred on the date and hour stated above.

Immediate cause of death respiratory failure Duration \_\_\_\_\_

Due to respiratory paralysis

Due to acute poliomyelitis

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(a) Means of injury \_\_\_\_\_

23. Signature C. P. Vermillion (M. D. or other)  
Address Barnes Hospital Date signed 10/3/48

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

300  
47  
39  
908

**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 *Gustav Peterle*

Licensed Embalmer No. *4329*

P. O. Address *St. Louis, 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.**