

FILED NOV 25 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38627

State File No. 9749

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Illinois</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Missouri</b>		c. LENGTH OF STAY (in this place) <b>3 mo. + 23 days</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Quincy</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Barnes Hospital, //</b>				d. STREET ADDRESS (If rural, give location) <b>W R - 18 33 Spring</b>			
3. NAME OF DECEASED (Type or Print)		a. (First) <b>Edna</b>		b. (Middle)		c. (Last) <b>Daniels</b>	
4. DATE OF DEATH		(Month) <b>Nov.</b>		(Day) <b>7</b>		(Year) <b>1949</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>9-3-1894</b>	
9. AGE (In years last birthday) <b>54</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 2 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>		11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Charles Campbell</b>		13b. MOTHER'S MAIDEN NAME <b>Anne Henry</b>		14. NAME OF HUSBAND OR WIFE <b>Ray</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Ray Daniels Quincy 211</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Bronchopneumonia</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: <b>Degenerative Brain disease</b> DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <b>6 1/2 hrs.</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>872</b>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>343X</b>			
22. I hereby certify that I attended the deceased from <b>July 15</b> , 19 <b>49</b> , to <b>Nov. 7</b> , 19 <b>49</b> , that I last saw the deceased alive on <b>Nov. 7</b> , 19 <b>49</b> , and that death occurred at <b>2:45 P.m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>F. H. Bradley M.D.</b> (Degree or title)				23b. ADDRESS <b>Barnes Hospital,</b>		23c. DATE SIGNED <b>11/7/49</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>11-8-49</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Frankford</b>		24d. LOCATION (City, town, or county) (State) <b>Me</b>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>NOV 12 1949</b>		REGISTRAR'S SIGNATURE <b>J. B. Sauter</b>		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <b>Rowland Mortu</b>			

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

6726

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Van M Sezenore

Licensed Embalmer No. 4343

P. O. Address OTKennis 10 70

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.