

FILED DEC 30 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **42567**  
Registrar's No. **9731**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY <b>0</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>4376</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>37 University City 1</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Lutheran Hospital</b>		d. STREET ADDRESS (If rural, give location) <b>8263 Montreal Dr.</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>EDWARD</b> b. (Middle) <b>JOHN</b> c. (Last) <b>MAHER</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Nov. 15 1950</b>			
5. SEX <b>Male 0</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single 2</b>	8. DATE OF BIRTH <b>Jan. 15, 1946</b>	9. AGE (In years last birthday) <b>4</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>St. Louis, Mo. 0</b>		12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME <b>James W. Maher</b>		13b. MOTHER'S MAIDEN NAME <b>Audrey Rose Andrews</b>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>James W. Maher</b> ADDRESS <b>8263 Montreal Dr.</b>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pneumonia; aspiration</b>		DUE TO (b) <b>Post Tonsillectomy Complication</b>			<b>1 day</b>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c)				
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						

19a. DATE OF OPERATION <b>11/14/50</b>		19b. MAJOR FINDINGS OF OPERATION <b>Hypertrophied tonsils &amp; adenoids...</b>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>510.1</b>		

22. I hereby certify that I attended the deceased from **7/14**, 19**50**, to **7/15**, 19**50**, that I last saw the deceased alive on **7/15**, 19**50**, and that death occurred at **7:00 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>E. J. Cason, M.D.</b> (Degree or title) <b>0</b>		23b. ADDRESS <b>3606 Travis</b>		23c. DATE SIGNED <b>11/15/50</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial 0</b>		24b. DATE <b>Nov. 18, 1950</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	
				24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>	

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>NOV 1 1950</b> <b>J. B. Pasater</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Kriegshauser</b> ADDRESS <b>4228 S. Kingshighway Bl.</b>	
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(Licensed Embalmer's Statement on Reverse Side)

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

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

working under my personal supervision.

Signed.....  
Student Embalmer

Signed.....

Student Embalmer No.....

*Edwin M. Bennett*

Licensed Embalmer No.....

*3024*

P. O. Address.....

**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.**