

THE DIVISION OF HEALTH OF MISSOURI
 FILED JUN 20 1953 STANDARD CERTIFICATE OF DEATH

State File No. **22817**
 Registrar's No. **5478**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY 2119	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 3655 Windsor	

3. NAME OF DECEASED (Type or Print)	a. (First) Daniel	b. (Middle)	c. (Last) Edmonds	4. DATE OF DEATH (Month) (Day) (Year) May 29 1953
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 7 July 1888	9. AGE (In years last birthday) 64	10. MONTHS	11. DAYS	12. HOURS	13. MIN.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Vicksburg, Miss		12. CITIZEN OF WHAT COUNTRY? U.S.		

13a. FATHER'S NAME Daniel Edmonds	13b. MOTHER'S MAIDEN NAME Elizabeth Jones	14. NAME OF HUSBAND OR WIFE Sylvia Edmonds
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME James Dixon	ADDRESS 4734a Newcolm Pl.
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Undet.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Cardiovascular Disease		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Congestive Failure DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Secondary Anemia			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR 443x

22. I hereby certify that I attended the deceased from **5-11**, 19**53**, to **5-29**, 19**53**, that I last saw the deceased alive on **5-29**, 19**53**, and that death occurred at **4:40p** m., from the causes and on the date stated above.

23a. SIGNATURE Edward Brooks M.D.	23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 6-1-53
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24a. BURIAL, CREMATION, REMOVAL removal	24b. DATE 4 June 53	24c. NAME OF CEMETERY OR CREMATORY Washington Park	24d. LOCATION (City, town, or county) (State) St. Louis, County Mo.
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DATE REC'D BY LOCAL REG. JUN 2 1953	REGISTRAR'S SIGNATURE Charles Smith	GENERAL DIRECTOR'S SIGNATURE Metropolitan Funeral Sys	ADDRESS 5010 Enright
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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Paul Freeman

Licensed Embalmer No.

4686

P. O. Address

458 S Alder

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.