

FILED SEP 16 1954

STANDARD CERTIFICATE OF DEATH

32304
State File No. 7949

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE		b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN		c. CITY OR TOWN		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. LENGTH OF STAY (in this place) 3 mo		e. STREET ADDRESS (If rural, give location)		0570 None	
d. FULL NAME OF HOSPITAL OR INSTITUTION Incarnate Word Hospital					

3. NAME OF DECEASED (Type or Print) a. (First) Edna		b. (Middle) Samantha		c. (Last) Waid		4. DATE OF DEATH (Month) (Day) (Year) August 26, 1954	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH June 16, 1888	
9. AGE (In years last birthday) 66		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		IF UNDER 1 HR. Hour Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (City and State or Foreign Country) Adkinson, Ark.	
12. CITIZENSHIP OF WHAT COUNTRY? U.S.A.							

13a. FATHER'S NAME William Wells		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Rupert Waid	
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 Rupert Waid, Hawk Point, Mo.	
ADDRESS					

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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Carcinoma of Transverse Colon</i>				INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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. _____					

19a. DATE OF OPERATION 6-20-54		19b. MAJOR FINDINGS OF OPERATION <i>Perforated Carcinoma of Transverse Colon with distant metastasis to lung</i>				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? 153X			

22. I hereby certify that I attended the deceased from 6-18, 1954, to 8-26, 1954, that I last saw the deceased alive on 8-26, 1954, and that death occurred at 5:40 P.M., from the causes and on the date stated above.

22a. SIGNATURE <i>Herman J. Klobner B.S.</i>		(Degree or title)		22b. ADDRESS 9621 Hubbard St		22c. DATE SIGNED 8-27-54	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE August 30, 1954		24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.	
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DATE REC'D BY LOCAL REG. AUG 27 1954		REGISTRAR'S SIGNATURE <i>J. Earl Smith M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Beiderwieden F.H. Inc., 1936 St. Louis A v			
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B.O. (Licensed Embalmer's Statement on Reverse Side)

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

7021 JACKSON RD
Overland, Mo.
Phone 777 8-1855

Hours: 2-4 PM (3rd mo Wed)

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 _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 452

P. O. Address St. Louis

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.