

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39038

State File No. 10305

FILED DEC 2 1955

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 Missouri | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | c. LENGTH OF STAY (In this place) 15 yrs. | | c. CITY OR TOWN St. Louis | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital | | STREET ADDRESS (If rural, give location) 10 4285 St. Louis 21870 | | | |

| | | | | | |
|--|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) Edward Everett H. b. (Middle) c. (Last)† Wilkins | | | 4. DATE OF DEATH (Month) (Day) (Year) 11 22 55 | | |
|--|--|--|--|--|--|

| | | | | | | | | | | | | | |
|-------------|--|---------------------------|--|---|--|-----------------------------------|--|---------------------------------------|--|--|--|------------------------------------|--|
| 5. SEX M | | 6. COLOR OR RACE Negro | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | | 8. DATE OF BIRTH Dec. 25, 1895 | | 9. AGE (In years last birthday) 59 | | 10. IF UNDER 1 YEAR Months Days 10 | | 11. IF UNDER 24 HRS. Hours Min. | |
|-------------|--|---------------------------|--|---|--|-----------------------------------|--|---------------------------------------|--|--|--|------------------------------------|--|

| | | | | | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|--|--|-----------------------------------|--|--|--|
| 10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Mail Handler | | | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Post Office | | | | 11. BIRTHPLACE (City and State or Foreign Country) Arkansas | | | | 12. CITIZEN OF WHAT COUNTRY? 1 | | | |
|--|--|--|--|---|--|--|--|--|--|--|--|-----------------------------------|--|--|--|

| | | | | | | | | | | | |
|-------------------------------------|--|--|--|--|--|--|--|--|--|--|--|
| 13a. FATHER'S NAME John B. McKim | | | | 13b. MOTHER'S MAIDEN NAME Lena Murphy | | | | 14. NAME OF HUSBAND OR WIFE Eva McKim | | | |
|-------------------------------------|--|--|--|--|--|--|--|--|--|--|--|

| | | | | | | | | | | | | | | | |
|--|--|--|--|-------------------------|--|--|--|---|--|--|--|---------------------------|--|--|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give part or dates of service) Yes W.W.I. | | | | 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT'S SIGNATURE OR NAME Joseph McKim | | | | ADDRESS 4205 St. Louis | | | |
|--|--|--|--|-------------------------|--|--|--|---|--|--|--|---------------------------|--|--|--|

| | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|
| 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 | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Undt. | | | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular Accident | | | | | | | | | | | | DUE TO (b) Antecedent Causes Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | DUE TO (c) | | | | | | | | | | | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | | | | | | | | Arteriosclerosis Generalized | | | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | | | | | | |
|-----------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|
| 18. DATE OF OPERATION | | | | 19b. MAJOR FINDINGS OF OPERATION 331+ | | | | | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
|-----------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|

| | | | | | | | | | | | |
|------------------------------------|--|--|--|--|--|--|--|---|--|--|--|
| 21a. INCIDENT (Specify) Suicide | | | | 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) 11-7-55 | | | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21f. HOW DID INJURY OCCUR? | | | |
|--|--|--|--|--|--|--|--|----------------------------|--|--|--|

22. I hereby certify that I attended the deceased from 11-7, 1955, to 11-22, 1955, that I last saw the deceased alive on 11-22, 1955, and that death occurred at 10:45 p. m., from the causes and on the date stated above.

| | | | | | | | | | | | | | | | |
|------------------------------------|--|--|--|------------------------|--|--|--|----------------------------------|--|--|--|------------------------------|--|--|--|
| 23a. SIGNATURE Edw. B. Williams | | | | (Degree or title) M.D. | | | | 23b. ADDRESS 2601 N. Whittier | | | | 23c. DATE SIGNED 11-25-55 | | | |
|------------------------------------|--|--|--|------------------------|--|--|--|----------------------------------|--|--|--|------------------------------|--|--|--|

| | | | | | | | | | | | | | | | |
|---|--|--|--|---------------------------|--|--|--|---|--|--|--|--|--|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 24b. DATE Nov 28, 1955 | | | | 24c. NAME OF CEMETERY OR CREMATORY National Cemetery | | | | 24d. LOCATION (City, town, or county) (State) Jefferson, Missouri | | | |
|---|--|--|--|---------------------------|--|--|--|---|--|--|--|--|--|--|--|

| | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|--|--|--------------------------|--|--|--|
| DATE REC'D BY LOCAL REG. NOV 25 1955 | | | | REGISTRAR'S SIGNATURE Charles Smith M.D. | | | | 25. FUNERAL DIRECTOR'S SIGNATURE C. B. Roove | | | | ADDRESS 1221 N. Grand | | | |
|---|--|--|--|---|--|--|--|---|--|--|--|--------------------------|--|--|--|

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

last by 11-25-55

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 *Malvin Blackman*.....

Licensed Embalmer No. *398*

P. O. Address *1221 N. 24th*

- 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.