

Health, Welfare & Public Service  
 300  
 1-56  
 All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms with be listed. Coroner cannot certify to a death due to natural causes. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED OCT 16 1956

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

363770  
 STATE FILE NUMBER 8682

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY										
b. CITY (If outside corporate limits, give-TOWNSHIP only) OR TOWN <i>St. Louis</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>St. Louis</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>								
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>St. City Stays</i>			Length of stay in		d. STREET ADDRESS (If outside give location) <i>12560 Browns</i>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Gertrude</i> First Middle Last <i>Wedlock</i>				4. DATE OF DEATH Month <i>Apr</i> Day <i>1</i> Year <i>1956</i>										
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Negro</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) <i>47</i>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (One kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (City and state or country) <i>La.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13. FATHER'S NAME <i>Unknown</i>						14. MOTHER'S MAIDEN NAME <i>Unknown</i>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Coroner's Office Records</i> Address								
18. CAUSE OF DEATH [Enter only one cause per line in (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Esophagus</i> DUE TO (b) <i>150X</i> DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT-NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH				
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.														
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)			20f. CITY, TOWN, OR LOCATION			COUNTY			STATE		
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <i>6:44 A.M.</i> on the date stated above; and to the best of my knowledge, from the causes stated.														
22a. SIGNATURE <i>Joseph D. Linn</i> (Degree) <i>3</i>						22b. ADDRESS <i>1300 Clark</i>						22c. DATE SIGNED <i>9/1/56</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>9-30-56</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Anatomical Burro</i>				23d. LOCATION (City, town, or county) (State) <i>St. Louis, Mo.</i>						
24. REFRIGERATED TO <i>Rowland Aker Mortuary Service</i> 4104 Manchester Ave. St. Louis 10, Mo.					25. DATE RECD. BY LOCAL REG. <i>SEP 20 1956</i>			26. REGISTRAR'S SIGNATURE <i>Carl Smith, Mo.</i>						

(Licensed Embalmer's Statement on Reverse Side)

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**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.....

P. O. Address.....

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (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.