

FILED FEB 25 1957

 DEPARTMENT OF HEALTH AND HUMAN SERVICES
 STANDARD CERTIFICATE OF DEATH

318

1003

STATE FILE NUMBER

972

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Dent		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Salem		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Length of stay in 1b	d. STREET ADDRESS So. Washington St. (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MARIE Middle BESSIE Last EDMONSTON			4. DATE OF DEATH Month JAN Day 30 Year 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1889	9. AGE (In years last birthday) 67 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) Housework		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Poplar Bluff, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Unknown: Lawson			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Melvin Hebert, Salem, Mo.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RUPTURED AORTIC ANEURYSM					INTERVAL BETWEEN ONSET AND DEATH 1 DAY
DUE TO (b) _____					
DUE TO (c) _____					022X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CEREBRAL VASCULAR ACCIDENT 1 DAY DUE TO: ARTERIOSCLEROTIC HEART					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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 18.) DEATH			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month, Day, Year _____					
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 JAN. 29, 1957 to JAN. 30, 1957 and last saw her alive on JAN. 30, 1957 Death occurred at 5:20 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Reynold J. Lawson M. D. (Degree or title)			22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 1/30/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 1-30-57	23c. NAME OF CEMETERY OR CREMATORY Local		23d. LOCATION (City, town, or county) Salem, Mo. (State)
24. FUNERAL DIRECTOR Albert H. Hoppe, 4700 Washington Blvd. ADDRESS		25. DATE RECD. BY LOCAL REG. JAN 30 '57		26. REGISTRAR'S SIGNATURE J. Carl Smith MO	

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service

300
-56

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 Part I. No symptoms will be stated. All

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Robert M. Murray*

Licensed Embalmer No. *3749*

P. O. Address *St Louis*

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.