

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15382

FILED MAY - 8 1957

Registration District No. **318** Primary Registration District No. **1003** STATE FILE NUMBER **3896** Registrar's No. **3896**

Health,
& Welfare
Public
Service

S. 300
Y. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

| | | | |
|--|-------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN ST. LOUIS Yes <input type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN ST. LOUIS Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) Length of stay in lb INSTITUTION ST. LOUIS CITY HOSP. #1 92/ | | d. STREET ADDRESS 3427 WASHINGTON (Location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) EDWARD First TODD Middle TODD Last | | 4. DATE OF DEATH APRIL 3, 1957 Month Day Year | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH FEB. 18, 1879 |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 9b. KIND OF BUSINESS OR INDUSTRY none | 9c. AGE (In years last birthday) 78 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10b. KIND OF BUSINESS OR INDUSTRY none | 10c. AGE (In years last birthday) 78 |
| 11. BIRTHPLACE (City and state or country) ELGIN, ILLS. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME WILLIAM | | 14. MOTHER'S MAIDEN NAME EMMA VINTON | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give year or dates of service) UNKNOWN | | 16. SOCIAL SECURITY NO. UNKNOWN | |
| 17. INFORMANT ST. LOUIS CITY HOSP. #1. Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE - (a) myocardial infarct DUE TO (b) arteriosclerotic heart disease 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.) 4200 | |
| 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 3/27/57 to APRIL 3, 1957 and last saw her alive on APR. 3, 1957 Death occurred at 2:30 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) James M. Martin, M.D. | | 22b. ADDRESS 1515 LAFAYETTE AVE. | |
| 22c. DATE SIGNED 4/3/57 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 4-30-57 | |
| 23c. NAME OF CEMETERY OR CREMATORY Anatomical Board | | 23d. LOCATION (City, town, or county) (State) St. Louis, Mo. | |
| 24. FUNERAL DIRECTOR Rowland-Aker Mortuary Service ADDRESS 4104 Manchester Ave. | | 25. DATE RECD. BY LOCAL REG. APR 24 '57 | |
| | | 26. REGISTRAR'S SIGNATURE Carl Smith MO | |

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. (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.