

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

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

FILED JUL 16 1957

26069

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5228**

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST LOUIS</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Overland 423X (14)</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>De PAUL Hosp</b>		Length of stay in lb	27 STREET ADDRESS <b>2502 Spencer</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>JOHN TONER EDWARDS</b> First Middle Last			4. DATE OF DEATH Month <b>6</b> Day <b>3</b> Year <b>1957</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-20-1897</b>
9. AGE (In years last birthday) <b>60</b>		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) <b>FOREMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>LINCOLN MERCURY</b>	11. BIRTHPLACE (City and state or country) <b>BELTON - Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>ROBERT LIGHTFOOT EDWARDS</b>	
14. MOTHER'S MAIDEN NAME <b>MINNIE MOULTEN</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES 1st World War</b>	
16. SOCIAL SECURITY NO. <b>488-07-3629</b>		17. INFORMANT Address <b>MOLLIE EDWARDS 2502 SPENCER</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac insufficiency</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hypertensive arteriosclerotic cardiovascular disease</b> DUE TO (c) _____ PART II. - OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>443X</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>
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 _____ 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 <b>July 13, 1956</b> to <b>June 3, 1957</b> and last saw <sup>her</sup> <del>him</del> alive on <b>June 3, 1957</b> Death occurred at <b>1200 Union</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>John T. Lenton, M.A.</b>		22b. ADDRESS <b>634 N. Grand Blvd.</b>	22c. DATE SIGNED <b>June 4, 1957</b>
23a. BURIAL, CREMATION, REINTERMENT, Spec (u) <b>BURIAL</b>	23b. DATE <b>6-6-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Va. Halla</b>	23d. LOCATION (City, town, or county) (State) <b>Pagedale Missouri</b>
24. FUNERAL DIRECTOR <b>Earl Hilleman</b>		ADDRESS <b>9709 Lachland</b>	25. DATE RECD. BY LOCAL REG. <b>JUN 4 '57</b>
26. REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b>			

(Licensed Embalmer's Statement on Reverse Side)

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 *Loren E. Percy*.....

Licensed Embalmer No. ....

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.