

FILED JAN 7 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **46800**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500** Registrar's No. **3295**

|                                                                                                      |  |                                                                                                                                               |                                                      |
|------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Louis</b>                                                      |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b> |                                                      |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>(Rural)-Normandy</b> |  | c. LENGTH OF STAY (In this place) <b>1 Year</b>                                                                                               | c. CITY OR TOWN <b>Rural- Normandy</b> <b>4190 D</b> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>2630 Lyndhurst</b>                                        |  | STREET ADDRESS (If rural, give location) <b>2630 Lyndhurst</b>                                                                                |                                                      |

|                                                                                                                   |  |  |                                                               |  |  |
|-------------------------------------------------------------------------------------------------------------------|--|--|---------------------------------------------------------------|--|--|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <b>MATTIE</b> b. (Middle) <b>IRENE</b> c. (Last) <b>EDWARDS</b> |  |  | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>Dec. 26, 1957</b> |  |  |
|-------------------------------------------------------------------------------------------------------------------|--|--|---------------------------------------------------------------|--|--|

|                      |                               |                                                                       |                                       |                                           |                                         |                                        |
|----------------------|-------------------------------|-----------------------------------------------------------------------|---------------------------------------|-------------------------------------------|-----------------------------------------|----------------------------------------|
| 5. SEX <b>Female</b> | 6. COLOR OR RACE <b>White</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b> | 8. DATE OF BIRTH <b>April 6, 1881</b> | 9. AGE (In years last birthday) <b>76</b> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 1 RES. Hours _____ Min. _____ |
|----------------------|-------------------------------|-----------------------------------------------------------------------|---------------------------------------|-------------------------------------------|-----------------------------------------|----------------------------------------|

|                                                                                                               |  |                                                     |  |                                                                              |  |                                         |  |
|---------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|--|------------------------------------------------------------------------------|--|-----------------------------------------|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Home Maker</b> |  | 11. BIRTHPLACE (City and State or Foreign Country) / <b>Greenfield Tenn.</b> |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b> |  |
|---------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|--|------------------------------------------------------------------------------|--|-----------------------------------------|--|

|                                           |  |                                               |  |                                                       |  |
|-------------------------------------------|--|-----------------------------------------------|--|-------------------------------------------------------|--|
| 13a. FATHER'S NAME <b>William Pipkins</b> |  | 13b. MOTHER'S MAIDEN NAME <b>Martha Earls</b> |  | 14. NAME OF HUSBAND OR WIFE <b>Charles H. Edwards</b> |  |
|-------------------------------------------|--|-----------------------------------------------|--|-------------------------------------------------------|--|

|                                                                                                                     |  |                                     |  |                                                                                     |  |
|---------------------------------------------------------------------------------------------------------------------|--|-------------------------------------|--|-------------------------------------------------------------------------------------|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>no</b> |  | 16. SOCIAL SECURITY NO. <b>NONE</b> |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Estelle Herman 2630 Lyndhurst</b> |  |
|---------------------------------------------------------------------------------------------------------------------|--|-------------------------------------|--|-------------------------------------------------------------------------------------|--|

|                                                                                                                                                                                                                                   |                                                                                                                                                                            |  |                                                  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br><br><i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i> | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Myocardial Infarction</b>                                                               |  | INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b> |
|                                                                                                                                                                                                                                   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>Arterio sclerotic heart disease</b> |  | <b>3 years</b>                                   |
|                                                                                                                                                                                                                                   | DUE TO (c) <b>H/200</b>                                                                                                                                                    |  |                                                  |
|                                                                                                                                                                                                                                   | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.                                        |  |                                                  |

|                        |                                  |  |                                                                                              |  |
|------------------------|----------------------------------|--|----------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION |  | 20. AUTOPSY? <b>2</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
|------------------------|----------------------------------|--|----------------------------------------------------------------------------------------------|--|

|                                          |                                                                                          |                                                 |
|------------------------------------------|------------------------------------------------------------------------------------------|-------------------------------------------------|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 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) | 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 **1954**, to **Dec 20, 1957**, that I last saw the deceased alive on **Dec 20, 1957**, and that death occurred at **7:40 A.M.**, from the causes and on the date stated above.

|                                                           |  |                                                   |                                  |
|-----------------------------------------------------------|--|---------------------------------------------------|----------------------------------|
| 23a. SIGNATURE <b>N. P. Brown Jr MD</b> (Degree or title) |  | 23b. ADDRESS <b>3720 Washington St. Louis, Mo</b> | 23c. DATE SIGNED <b>12/27/57</b> |
|-----------------------------------------------------------|--|---------------------------------------------------|----------------------------------|

|                                                         |                           |                                                                |                                                                           |
|---------------------------------------------------------|---------------------------|----------------------------------------------------------------|---------------------------------------------------------------------------|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> | 24b. DATE <b>12/28/57</b> | 24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Lebanon Cemetery</b> | 24d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo.</b> |
|---------------------------------------------------------|---------------------------|----------------------------------------------------------------|---------------------------------------------------------------------------|

|                                          |                                               |                                                                                 |
|------------------------------------------|-----------------------------------------------|---------------------------------------------------------------------------------|
| DATE REC'D BY LOCAL REG. <b>12-27-57</b> | REGISTRAR'S SIGNATURE <b>Berbert Brown MD</b> | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Cully Kelly 7267 Natural Bridge</b> |
|------------------------------------------|-----------------------------------------------|---------------------------------------------------------------------------------|

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

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 E. Lewis Province

Licensed Embalmer No. 3402

P. O. Address Jennings,

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.