Health, Welfare Public Service

300
1-57

FILED MAR 10 1958

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-007606
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1943

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION: FirminDesloge Hosp. — Length of stay in Hospital: 5 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY: St. Louis
c. CITY OR TOWN: Rock Hill — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 2838 Dunkirk Dr. — Reside on Farm: Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print): First: EDWARD Middle: B. Last: MUNDY

4. DATE OF DEATH: Month: February Day: 17 Year: 1958

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 11-10-1882
9. AGE (In years last birthday): 75 — 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): Operator (retired)
10b. KIND OF BUSINESS OR INDUSTRY: Transportation
11. BIRTHPLACE (City and state or country): Catawissa, Mo.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Bernard Mundy
13b. MOTHER'S MAIDEN NAME: Julie Higgins
14. NAME OF HUSBAND OR WIFE: Minnie Helm Mundy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Minnie Mundy, Address: above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Congestive Heart Failure — 1 wk
DUE TO (c) Arteriosclerotic Heart Disease — Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Anemia

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.): 420.0
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 2-13-58, to 2-17-58 and last saw her/him alive on 2-16-58
Death occurred at 8:02 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: James C. Redington (Degree or title) M.D.
22b. ADDRESS: Clayton & Brentwood Blvd. Brentwood, Mo.
22c. DATE SIGNED: 2-17-58

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 2-19-1958
23c. NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis Co., Mo.

24. FUNERAL DIRECTOR: JAY B. SMITH, Maplewood, Mo. ADDRESS
25. DATE RECD. BY LOCAL REG.: FEB 18 '58
26. REGISTRAR'S SIGNATURE: Carl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 H. P. Burgess

Licensed Embalmer No. 402

P. O. Address Maplewo

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.