

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-012345

State File No.

FILED MAR 19 1958

318

1003

BIRTH NO.

REG. DIST. NO.

PRIMARY REG. DIST. NO.

Registrar's No. 2951

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri		b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. LENGTH OF STAY (in this place) 40 years		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 31 St. Louis State Hospital		STREET ADDRESS (If rural, give location) 690 1493 Arlington Ave.			
3. NAME OF DECEASED (Type or Print) Edward		a. (First)		b. (Middle)	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Unknown	
8. DATE OF BIRTH 10-6-76		9. AGE (in years last birthday) 81		10. DATE OF DEATH 3 12 1958	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY -0-----		11. BIRTHPLACE (City and State or Foreign Country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT'S SIGNATURE OR NAME Emil C. Stamm		ADDRESS Box 5141 Bennings P.O. Stamm-Washington, D.C.		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) * This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 10 min.	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic heart disease		DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 420.0					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? 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) m.		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 1-17, 1913, to 3-12, 1958, that I last saw the deceased alive on 3-12, 1958, and that death occurred at 6:30 a. m., from the causes and on the date stated above.					
23a. SIGNATURE A. Stojniak, M.D.		(Degree of title)		23b. ADDRESS 5400 Arsenal St.	
23c. DATE SIGNED 3-12-58		24a. NAME OF CEMETERY OR CREMATORY Bethany Cemetery		24b. LOCATION (City, town, or county) (State) St. Louis Co., Missouri	
24c. DATE REC'D BY LOCAL REG. MAR 13 1958		REGISTRAR'S SIGNATURE WACKER-HELDERIE		25. FUNERAL DIRECTOR'S SIGNATURE 3634 Gravois	

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

MS

Signed.....

Robert Wheeler

Licensed Embalmer No. *2121*

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.