

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-015957
State File No.

FILED MAY 8 1958

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **4159**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY St Louis	
b. CITY (If outside corporate limits, write RURAL and give township) St Louis		c. LENGTH OF STAY (in this place) 2 2/3	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2817 HOWARD		e. STREET ADDRESS (If rural, give location) 2817 Howard	
3. NAME OF DECEASED (Type or Print) a. (First) EDWARD b. (Middle) HUNT c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) 4 14 58	
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 3-17-1899
9. AGE (In years last birthday) 59		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	11. BIRTHPLACE (City and State or Foreign Country) Little Rock Ark.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Not known	
13b. MOTHER'S MAIDEN NAME not known Mary Watt		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES W.W.#1		16. SOCIAL SECURITY NO. 495.14.6394	
17. INFORMANT'S SIGNATURE OR NAME James Wyatt		ADDRESS 3763 Cook	
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, asthma, etc. It means the disease, injury, or complication which caused death. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lobar Pneumonia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 490X		INTEGRAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 7:50A m., from the causes and on the date stated above.			
23a. SIGNATURE James M. Keel, M.D.		23b. ADDRESS 1300 Black	
23c. DATE SIGNED 4-16-58			
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE 4-18-58	
24c. NAME OF CEMETERY OR CREMATORY National Cem.		24d. LOCATION (City, town, or county) (State) Jafferson Barracks, Mo	
DATE REC'D BY LOCAL REG. APR 16 '58		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE A.P. Richardson		ADDRESS 2625 Glasgow	

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 *AD Richardson*

Licensed Embalmer No. *292*

P. O. Address *City*

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.