

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

**58-019403**

STATE FILE NUMBER

FILED MAY 20 1958

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 184

health, Welfare public service  
 094  
 0300  
 1-56  
 All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 2-2-58

|                                                                                                                                                                                                                                               |                                  |                                                                                                                                                             |                                                                                                                                                 |                                                       |                                                                                                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Francois</b>                                                                                                                                                                                            |                                  |                                                                                                                                                             | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>St. Francois</b> |                                                       |                                                                                                   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR <b>Bonne Terre, Mo.</b>                                                                                                                                                       |                                  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                        | c. CITY OR TOWN <b>Rivermines</b>                                                                                                               |                                                       | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>              |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION<br><b>Bonne Terre Hosp</b>                                                                                                                                        |                                  | Length of stay in lb<br><b>10 Da.</b>                                                                                                                       | d. STREET ADDRESS (If outside, give location)                                                                                                   |                                                       | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>             |
| 3. NAME OF DECEASED (Type or print)<br>First <b>LESLIE</b> Middle <b>HARRY</b> Last <b>EDWARDS</b>                                                                                                                                            |                                  |                                                                                                                                                             | 4. DATE OF DEATH <b>May 12, 1958</b>                                                                                                            |                                                       |                                                                                                   |
| 5. SEX<br><b>male</b>                                                                                                                                                                                                                         | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Oct-3-1895</b>                                                                                                           | 9. AGE (In years last birthday) <b>62</b>             |                                                                                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Miner</b>                                                                                                                                   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Lead</b>                                                                                                            | 11. BIRTHPLACE (City and state or country)<br><b>Doe Run, Missouri</b>                                                                          |                                                       | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                     |
| 13. FATHER'S NAME<br><b>William Edwards</b>                                                                                                                                                                                                   |                                  |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><b>Monte Horton</b>                                                                                                 |                                                       |                                                                                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>                                                                                                                        |                                  | 16. SOCIAL SECURITY NO.<br><b>493-03-9032</b>                                                                                                               | 17. INFORMANT <b>Bessie Edwards</b> Address <b>Rivermines, Mo.</b>                                                                              |                                                       |                                                                                                   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction</b>                                                                                 |                                  |                                                                                                                                                             |                                                                                                                                                 |                                                       | INTERVAL BETWEEN ONSET AND DEATH<br><b>12 days</b>                                                |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.                                                                                                                                                    |                                  |                                                                                                                                                             |                                                                                                                                                 |                                                       | DUE TO (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)                                                                                                             |                                  |                                                                                                                                                             |                                                                                                                                                 |                                                       | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 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 _____ a. m. _____ p. m.                                                                                                                                                                                                   |                                  |                                                                                                                                                             |                                                                                                                                                 |                                                       |                                                                                                   |
| 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 <b>4201</b> COUNTY STATE |                                                                                                   |
| 21. I attended the deceased from <b>May 1, 1958</b> to <b>May 12, 1958</b> and last saw him alive on <b>May 12-58</b><br>Death occurred at <b>3:00 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated. |                                  |                                                                                                                                                             |                                                                                                                                                 |                                                       |                                                                                                   |
| 22a. SIGNATURE <b>C. E. Carleton M.D.</b> (Degree or title)                                                                                                                                                                                   |                                  |                                                                                                                                                             | 22b. ADDRESS <b>Farmington, Mo.</b>                                                                                                             |                                                       | 22c. DATE SIGNED <b>5-13-58</b>                                                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                    |                                  | 23b. DATE<br><b>May 14, 1958</b>                                                                                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Francois Memo.</b>                                                                                 |                                                       | 23d. LOCATION (City, town, or county) (State)<br><b>St. Francois Co. Mo.</b>                      |
| 24. FUNERAL DIRECTOR <b>Murphy L. Sparks</b> ADDRESS <b>Flat River, Mo.</b>                                                                                                                                                                   |                                  |                                                                                                                                                             | 25. DATE RECD. BY LOCAL REG.<br><b>May 13, 1958</b>                                                                                             | 26. REGISTRAR'S SIGNATURE<br><b>Cather Rudloff</b>    |                                                                                                   |

MAY 23 1958

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 *Murphy L. Sp...*

Licensed Embalmer No. *42*

P. O. Address *Flat River*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.